DOCTOR OF PHILOSOPHY

"Even the dog has Attention Deficit Hyperactivity Disorder" (ADHD). A cross-cultural comparative study of parents' and teachers' knowledge and attitudes towards ADHD in Scotland and Romania

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"Even the dog has Attention Deficit Hyperactivity Disorder" (ADHD)

A cross-cultural comparative study of parents' and teachers' knowledge and attitudes towards ADHD in Scotland and Romania

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Declaration

I declare that I have composed this thesis by myself and that it embodies the results of my own research. Where appropriate, I have acknowledged the nature and extent of work carried out in collaboration with others included in the thesis.

Madalina Teodora Toma

Dedication

I would like to dedicate this thesis to the loving memory of my father and best friend, who unfortunately did not get to see the finished thesis. He was and he remains a constant inspiration to me.

O sa ramai mereu in sufletul meu!

Acknowledgments

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Abstract

The aim of this research was to investigate the way in which ADHD is understood and constructed within Romania and Scotland, comparing and contrasting the discourses that constitute ADHD within different cultural contexts. Overall, this study employed a mixed method design based on a concurrent nested approach which was undertaken in 2 phases. In phase 1, 50 parents, 72 primary school teachers and 48 support staff from Scotland, and 50 parents, 86 primary school teachers and 57 support staff from Romania, completed a self-report questionnaire that measured their knowledge and attitudes towards ADHD. The statistical results showed that, for the knowledge of ADHD test, both sample of parents, teachers and support staff scored the highest at symptoms/diagnosis subscale. Parents, teachers and support staff from the Romanian sample scored the lowest at the treatment subscale whereas the Scottish respondents had difficulties in answering questions about the nature, causes and prognosis of ADHD. In terms of their self-reported attitudes, both samples of Scottish and Romanian parents, teachers and support staff scored the highest on the affective attitude subscale. Scottish teachers and support staff scored the lowest on the behavioural attitude subscale whereas Romanian teachers and support staff scored the lowest on the cognitive attitude subscale. On the other hand, both samples of Scottish and Romanian parents scored the lowest on the behavioural attitude subscale. These patterns were further explored in phase 2 of the study, where 5 Scottish and Romanian mothers, 3 Scottish and Romanian primary-school teachers and 3 Scottish and Romanian support staff were selected to take part in a semi-structured interview. Parents, teachers and support staff from both countries responded within a medical model of disability employing themes such as ADHD as a medical condition, the medicalisation of behaviour, behaviour as out of control or the specialness of ADHD. However, participants also adopted a social conceptualisation of ADHD, referring to ADHD as a social phenomenon, resisting medicalisation and describing the educational and medical "wrongs". Reflecting the uncertainty in the field, participants' conceptualisation of ADHD expanded, modified or even shifted from one perspective to another. The cross-cultural comparisons used the Appadurai's theoretical framework of "scapes" to explain the global nature of ADHD as well as the differences between Scottish and Romanian parents, teachers and support staff in relation to the three most important results of this study: treatment of ADHD, inclusion of children diagnosed with ADHD in mainstream education and parents' and teachers' willingness to get involved. The findings have been used to develop a multidisciplinary framework for support, empowering teachers and parents with knowledge of ADHD and improving cross-professional relationships. The fundamental idea of this framework is that it moves beyond the deficit paradigm, helping teachers, parents and stakeholders to be alert and responsive to the various conceptualisations of ADHD and to understand how these schemata have come into existence in specific periods of time and in different cultural contexts.

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1. Introduction

1.1. Rationale of the study

This study aimed to gain an understanding of teachers' and parents' knowledge and attitudes towards ADHD in two different cultural contexts. A considerable part of this thesis evolved from my early interest in ADHD. Starting with my undergraduate studies, I was interested in the way in which ADHD was assessed by various professionals, offering a new perspective on the current trend in ADHD psycho-diagnosis. From a medical angle, I conducted a number of research projects focusing on the efficacy of cognitive-behavioural and psycho-stimulant therapy. My interest in ADHD was fueled even more by my work as an educational psychologist for one local Romanian primary school and the significant number of students diagnosed with ADHD that I was seeing in my practice. As a result, looking at ADHD within the school setting, for my Master of Arts in Educational Studies, I explored the complex relationship between low self-esteem and children's academic underachievement. The outcomes of the study revealed that children diagnosed with ADHD had difficulties in controlling impulses, inhibiting their behavior and sustaining their attention span, patterns that, within the closed, repetitive conditioning home and school situation, became exaggerated and ultimately backfire. In this context, I acknowledged that a considerable part of my previous research overlooked the importance of the role played by teachers in the complex arena of ADHD. Therefore, as a part of my second degree, Master of Research in Educational Research, I investigated the relationship between teachers' socio-demographic characteristics, their knowledge and their attitudes towards ADHD in primary school. The results showed that, in many circumstances,

teachers had a lack of information, misconceptions and negative attitudes towards their students with additional support needs. This was the starting point in realising that, in working effectively with children diagnosed with ADHD, many factors have to be considered. Not only teachers, but also parents have important views and need the opportunity to have their opinions heard.

Given the competing discourses about ADHD, it has become a paramount issue to understand and explore teachers' and parents' knowledge and attitudes towards ADHD along with their perceptions, meanings and experiences. Furthermore, since different cultural groups are sources of information about essentially the same phenomena, I decided to look at how ADHD was conceptualised in Scotland and Romania and to seek to understand its meaning and its associations with other cultural-specific factors. Understanding cultural differences in knowledge and attitudes relating to ADHD represented a particularly suitable point of departure for integrated understanding of a phenomenon such as ADHD, allowing me to make initial tests of propositions of the cultural specificity or formulation of disordered behaviour. This was particularly important in countries, such as Romania, where specialised paediatric services were limited, the majority of schools were dealing with an under-resourced educational system and multidisciplinary focus was lacking. However, undertaking a cross-cultural comparison of various knowledge and attitudinal patterns was a very complex task. In this sense, I cannot pretend that my findings are universally applicable. What I aim to present in this thesis is an original way of approaching Scottish and Romanian teachers' and parents' conceptualisation of ADHD, using my own skills as researcher with practical experience in both cultural settings.

1.2. Significance of the problem and research context

ADHD is a common neuropsychiatric disorder diagnosed in between 3 % and 7 % of school-age children and is characterised by a number of problematic behaviours (e.g. Barzman, Fieler & Sallee, 2004). It is one of the most frequent and fastest growing diagnoses among children in the United States and is increasing at a rapid rate in all countries throughout the world. ADHD is also currently one of the most researched conditions but yet it is not fully understood. In this sense, it is important to mention that, before commencing the research, I, as researcher, did not make any assumptions about the physical, social or cultural existence of ADHD. However, in order to set the scene for this study, attention was given to the amount and style of thought researchers in the past have shown in exploring the diagnosis. (Helmerichs, 2002) Indeed, ADHD is said to affect children across multiple domains of functioning and across multiple settings. During a critical period of social, psychological and physical development, the home and school environments are the most significant. As teachers and parents represent pivotal elements in the formative years of children, the knowledge and attitudes that they have about ADHD are paramount. This is particularly important since teachers and parents are also in a position to influence the attitudes held by the general public towards this category of children. Their knowledge and attitudes could encourage positive viewpoints or negative and discriminatory stereotypes which in turn might have a negative impact on students' social and emotional development. Furthermore, teachers and parents often become the liaison between the child, the social worker, the psychologist and medical practitioners, facilitating or hindering the multidisciplinary and interagency team work.

Although international guidelines consider teachers and parents to be crucial in the identification, treatment and prevention of the disorder, published papers have tended to focus on teachers and parents separately (e.g. Johnston, Murray, Hinshaw, Pelham, & Hoza) or have placed great emphasis on medical practitioners (e.g. Shaw, Wagner, Eastwood, & Mitchell, 2003). Whilst there is considerable evidence regarding the academic and social difficulties of children diagnosed with ADHD (e.g. McQuade, Hoza, Murray-Close, Waschbusch, & Owens, 2011), there seems to be limited qualitative or quantitative research on what teachers and parents know and what attitudes they adopt. Even when studies have looked at the various knowledge and attitudinal patterns, they have not taken into consideration the different ramifications of each construct in a mixed-method environment.

Furthermore, the majority of studies of ADHD issues to date continue to be based on assumptions of universality of the American mainstream experience (e.g. Alegría et al., 2004). So far, there is a scarcity of research findings from the developing countries and limited information is offered as to why the construction of ADHD varies between different socio-cultural contexts. The cultural expectations are different as well as the understanding of what is normal and how children should behave. Cultural differences should be acknowledged because the intervention in ADHD varies considerably by country as does the role of parents and teachers involved in the children's education. Although significant differences in knowledge and attitudes towards ADHD exist, the cultural and ethnic variations are often overlooked in research. My literature review revealed no published research, qualitative or quantitative, cumulatively looking at teachers' and parents' conceptualisation of ADHD by comparing and contrasting different cultural constructions

of disability. Furthermore, no previous investigation has involved a mixed method design to explore what teachers and parents know about ADHD and what attitudes they adopt.

Accordingly, the present study builds on previous literature by exploring and comparing the different types of knowledge and attitudes that Scottish and Romanian teachers, support staff and parents possess. The information gained from this study may therefore assist in developing a multidisciplinary framework for support, empowering teachers and parents with knowledge of ADHD and improving cross-professional relationships. The fundamental idea of this framework is that it moves beyond the deficit paradigm, helping teachers, parents and stakeholders to be alert and responsive to the various conceptualisations of ADHD and to understand how these schemata have come into existence in specific periods of time and in different cultural contexts. However, the significance of this study reaches far beyond the surface need for teachers' and parents' education about ADHD. The issue of teachers' and parents' knowledge and attitudes is one that should be of great concern to all stakeholders and society at large. By contrasting the way in which ADHD is conceptualised within Romanian and Scottish cultures, this study argues for a change in vision, a change that takes into consideration specific factors in a culturally sensitive manner.

1.3. Aim, objectives and research questions

The aim of this research is to investigate the way in which ADHD is understood and constructed within Romania and Scotland, comparing and contrasting the discourses that constitute ADHD within two different cultural contexts. The main aim also translates into two specific research objectives as follows:

- To investigate the knowledge and attitudes towards ADHD among a sample of Romanian and Scottish teachers, support staff and parents, looking at the way in which they create and construct meanings in their everyday life.
- To compare the knowledge and attitudes towards ADHD revealed by teachers, support staff and parents in Scotland and Romania, highlighting similarities as well as differences.

According to the aim and objectives, the research set out to investigate the following questions:

RQ 1-What kind of knowledge about ADHD do teachers, support staff and parents possess?

RQ 2-What are teachers', support staff' and parents' attitudes towards ADHD?

RQ 3-To what extent do significant similarities in attitudes and knowledge exist among the Scottish and Romanian samples of parents, teachers and support staff?

RQ 4- To what extent do significant differences in attitudes and knowledge exist among the Scottish and Romanian samples of parents, teachers and support staff?

1.4. Structure and organisation of the thesis

This thesis is divided into 8 chapters. This first introductory chapter presents the rationale of the study by delineating the contextual framework within which teachers' and parents' knowledge and attitudes towards ADHD are shaped. Additionally, a brief outline of the significance of the problem and the research context is described as a basis for exploring the knowledge and attitudinal patterns. An overview of the aim and research questions of the study is also stated. Following this, chapter 2 comprehensively reviews the literature on ADHD in relation to teachers' and parents' knowledge and attitudes. Chapter 3 describes the methodology of the study and includes the following elements: research design, sample, procedure, instrumentation, reliability and validity, ethical considerations and data analysis.

Chapter 4 details the results of the statistical analyses generated with the SPSS software according to each research question. Chapter 5 provides a thorough discussion of the quantitative findings, making connections with the literature and preparing the systematic qualitative analysis. Chapter 6 elaborates on the results introduced in the previous chapter and presents a thematic analysis of the interviews conducted with teachers, support staff and parents.

Chapter 7 focuses on the cross-cultural comparative analysis between the two countries by employing Appadurai's framework of "scapes". An overview of the similarities and differences obtained is presented. Additionally, the final chapter discusses the limitations of the study and points to future research directions for researchers

interested in expanding upon the results of this study. The chapter concludes the thesis by discussing the overall contribution of the research in the context of related work in the area. The implications for practice, training and research move forward from the traditional list of recommendations for teachers and parents and shift towards a novel view of ADHD from a critical perspective.

2. Literature review

2.1. Introduction

The literature chosen for inclusion helped to establish the theoretical framework for the present study and supported the underlying research purpose to explore teachers' support staff's and parents' knowledge and attitudes towards ADHD. Articles chosen for review pertained to the research questions, theoretical underpinnings of the research, and methodological issues. Since the subjectivity involved in the diagnosis of this disorder has become a problem of great significance of the 20th century, this chapter outlines firstly the history of nomenclature and defining features of what today is termed the Attention Deficit Hyperactivity Disorder (ADHD). The topics within this chapter cover an array of interrelated concepts including academic and psychological functioning of children diagnosed with ADHD, social and familial functioning, and treatment and intervention strategies. This first section is written from the perspective of the medical model of disability mainly because the growing knowledge base about ADHD in children and adults was centered on a deficit model. Many studies concentrated on the learning deficits, the social skills and psychosocial deficits, the memory deficits, impulsivity or the deficits of executive functioning of children diagnosed with ADHD. Following this discussion, the deficit literature is included to emphasise the existence of ADHD and represents a starting point for the next section, which reviews the other conceptualisations of the condition. Both

the medical and the social discourses associated with different literatures and persepectives are described, along with their relevance for understanding the way in which people experienced ADHD in their everyday life. Next, research exploring parents' and teachers' knowledge and attitudes towards ADHD is presented. The chapter concludes with details and information concerning the collaboration between teachers, parents and other professionals in the field of ADHD.

2.2. What and why of Attention Deficit Hyperactivity Disorder (ADHD)

The focus of this section is not to discuss in details the guidelines for diagnosis and treatment, but to provide a general overview of the prevalence, aetiology, symptoms and treatment of ADHD. This section describes the manifestations of ADHD within the family and school environment and how these contexts could have an important impact upon a child's educational and socio-emotional development.

2.2.1. What is ADHD? Prevalence, symptoms and diagnosis

According to Kaminester (1997), the first known reference to a hyperactive child dated from 1865 and it was related to the fidgety Philip portrayed in the poems of the German physician Heinrich Hoffman. In 1902, ADHD was recognised as a serious medical condition when George Still presented a series of lectures to the Royal College of Physicians. The author described 43 children who were often aggressive, lacking inhibitory volition and sustained attention. Since then, the disorder has been referred to by many different names such as Encephalitis Lethargica, Minimal Brain Dysfunction, Hyperkinesis or Attention Deficit Disorder (Rafalovich, 2001).

Regardless of the name used, ADHD is one of the most thoroughly researched disorders in the fields of medicine, education, sociology and psychology, with a prevalence of 5.29 % world-wide (Polanczyk et al., 2007). In the United Kingdom, the prevalence of ADHD in school-aged children and adolescents has been estimated at 5 % (National Institute for Health and Clinical Excellence, 2006). On the other hand, due to the lack of national epidemiological studies in Romania, very little is known about the general population prevalence or severity of ADHD.

According to Schneider and Eisenberg (2006), most children are first diagnosed with ADHD when they reach school age and approximately 75 % of those diagnosed are males. The first empirically based official set of diagnostic criteria for what is now referred to as ADHD, was introduced by the American Psychiatric Association (APA) when in 1987 it published the third revised version of Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The current classification (DSM-IV-R) included ADHD in axis 1

together with other clinical disorders like depression, autism spectrum disorder or phobias. The essential feature of ADHD is "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than typically observed in individuals at a comparable level of development" (312.9). There are currently 3 recognised subtypes of ADHD: predominantly inattentive, predominantly hyperactive/impulsive and combined.

Another major clinical diagnostic system is the International Classification of Diseases and Related Health Problems published by the World Health Organization. Its 10th revision (ICD-10, 2007) adopted the term Hyperkinetic Disorder, which was included in the category of behavioural and emotional disorders. The condition is characterised by "an early onset, lack of persistence in activities that require cognitive involvement and a tendency to move from one activity to another without completing any one, together with disorganised, ill-regulated, and excessive activity" (F 90).

2.2.2. Why children exhibit ADHD symptoms? The aetiology of ADHD

Researchers in this field have been uncertain about the underlying factors that cause ADHD. An extensive number of explanations have been offered suggesting that ADHD has a neurological basis. According to Leo and Cohen (2003), the scientific research surrounding the disorder was at times disconcerting because participants were often using psychostimulant medication before or during the actual study, a variable that might influence the validity of the reported results. Moreover, the aetiological explanations offered by the researchers were general indications about what might cause ADHD, without any specifications about the implication for the ADHD subtypes. Various theories

of ADHD aetiology are constantly being investigated, but how the wide varieties of these multifactorial causes interact to make up the disorder and its different manifestations is still unclear.

Although no immediate cause of ADHD is known (e.g. Shastry, 2004; Snider, Busch, & Arrowood, 2003), the most cited theories are based on functional imaging studies that suggested abnormalities in cerebral activation in ADHD, with a hypoperfusion of frontal and possibly striatal areas (e.g. Barkley, 1998; Durston et al., 2003; Rubia et al., 1999, 2001). There is no scientifically validated brain scan or blood test which confirms ADHD (Baughman, 2006; Dopheide, 2001), however, the magnetic resonance imaging studies conducted by Castellanos, Lee & Sharp, (2002), Eloyan et al., (2012) and Rapoport et al., (2001) pointed to a widespread cerebral reduction in volume associated with ADHD. In the same way, ADHD has been consistently associated with weaknesses in executive function domains (Willcutt, Pennington, Olson, Chhabildas & Hulslander, 2005). Futhermore, Castellanos and Proal (2011) have provided insights emerging from mapping intrinsic brain connectivity networks. They highlighted the possible role of the primary visual cortex in causing the dysfunctions associated with ADHD.

Large numbers of studies have been conducted showing that variants, genes and chromosomal regions are associated with ADHD. For instance, according to Arnsten (2000) and Maher, Marazita, Ferrell, & Vanyukov (2002) dysfunctions or imbalances in some neurotransmitters such as norepinephrine and dopamine also have been proposed as possible causes of ADHD. Other studies provided strong evidence for various genotypes pathways associated with ADHD (e.g. Cummins et al., 2011). Adoption studies have been clear in their implications regarding the hereditary nature of ADHD. Biederman (1999),

Cortese (2012), Faraone and Khan (2006) and Sherman et al., (1997) observed higher rates of psychopathology among the parents of children diagnosed with ADHD versus those without ADHD and among the biological parents of adopted children with ADHD than in adoptive parents of children with the same condition.

On the other hand, Evans (2003), Rall (2011) and Saab (2012) have claimed that environmental toxins, imbalanced diet, food allergies, antibiotic use, low levels of zinc, calcium or magnesium could trigger ADHD. Although not a primary cause, psychosocial factors have also been proposed as a possible contributory cause of ADHD. For example, Barkley, Anastopoulos, Guevremont, & Fletcher (1991) and O'Reilly (2007) have asserted that hyperactive behaviour was the result of poor parenting, cigarette smoking or alcohol consumption during pregnancy, low socioeconomic status or foster care.

2.2.3. How is ADHD treated?

As Goodley (2007) has ascertained, the phenomenon of ADHD has invoked a history of complex, overlapping processes of assessment, diagnosis, surveillance and special treatment. The majority of investigations on this topic manipulated a limited amount of information over a short period of time although academic and social impairments associated with ADHD might require significant longer time slots for testing. Further, how different subgroups of children were likely to benefit differentially from particular treatment combinations has not been clearly explained.

However, when it comes to treating children diagnosed with ADHD, the literature has supported the use of medication and other non-pharmacological intervention. Firstly,

methylphenidate[1] has been approved as a promising chemical for inattention in 1957 before the establishment of the concept of ADHD (Bahn, Bae, Moon, & Min, 2011). Subsequently, according to Bauermeister et al., (2003), Hoagwood, Kelleher, Feil, & Comer (2000) and Wender et al., (2011), bulk production of methylphenidate, pharmacy-based audits and physician-based surveys revealed increasing consumption of stimulants by children and adolescents diagnosed with ADHD. However, although the administration of psychostimulants might enhance the functioning of executive control processes, questions still remain about their effectiveness, tolerability and safety. Despite this, rates of diagnosis of psychiatric disorders in children and prescription of psychotropic medication have increased dramatically over recent years. According to the Institute for Healthcare Informatics, (2012), in 2009, the rate of prescription for methylphenidate (Ritalin) was 82.8 % but in 2011 the percentage increased to 85 % of all the prescriptions given to children diagnosed with ADHD within the European Union countries. However, compared to the United Kingdom, where the rate of methylphenidate prescription in 2011 was 71 %, Romania is the only country in the European Union where methylphenidate is very rarely seen as a treatment choice (e.g. 16 % prescription rate).

On the other hand, as Currier (2004) pointed out, non-pharmacological interventions have included the training of parents and school-based interventions. Those activities might be useful to build upon appropriate skills for children, reduce problems that

[1]*Methylphenidate (Ritalin,MPH,MPD) is a psychostimulant drug approved for treatment of ADHD, postural orthostatic tachycardia syndrome and narcolepsy.*

are often comorbid to ADHD and assist individuals that are experiencing dysfunction in other domains. According to Girio (2006), Ota and DuPaul (2002), and Weyandt and DuPaul (2012), teachers' contribution to the treatment of children with ADHD has consisted of various modifications of academic instruction including strategies like daily report cards, response-cost procedures, corrective feedback, administration of rewards and consequences, class-wide peer tutoring, communication with home or computer-assisted instructions. In addition, cognitive behavioural models have included more self-initiating intervention paradigms. For example, a child could be taught anger management and social skills, along with self-evaluation, self monitoring and self-reinforcement with the aim of helping the student to identify and modify the behavioural problems him/herself (Barry & Messer, 2003, Dopheide, 2001). However, decades of treatment, research and clinical practice has demonstrated the short-term strengths and limitations of both psychopharmacological and psychosocial treatment strategies. Indeed, there has been no consensus in the field of ADHD about an overall effective treatment, as each approach had weaknesses with respect to its outcomes. As Purdie, Hattie, & Carroll, (2002) argued, psychosocial interventions might result in higher cognitive outcomes, while pharmacological interventions could lead to higher behaviour modifications. Moreover, for some children, medication in combination with behavioural or psychosocial interventions may be more effective than either treatment alone (Jensen et al., 2001).

2.2.4. How does ADHD manifest within the school setting?

Pupils diagnosed with ADHD tend to do less well at school than their symptom-free peers. Research has consistently demonstrated the negative impact of ADHD on school performance (e.g. Iseman, 2012; Marshall, 1997), showing that many children diagnosed with ADHD achieve at a lower level "than would be predicted given their intellectual abilities" (DeShazo, 2002, p. 261). According to the authors, not only a categorical diagnosis of ADHD, but also the severity and pervasiveness of the ADHD symptoms could be interpreted as predictors of both academic underachievement and impaired relationships within the school environment. For instance, as Greenfield-Spira and Fischel (2005) and Saudino, Rogers, Asherson, & Kuntsi (2007) highlighted, children lacked basic academic skills and struggled with completing the tasks without engaging in distracted behaviour. One possible explanation was offered by Barkley (1998) and Brown (2001), who ascertained that children with ADHD were unable to achieve their potential mainly because they possessed several executive functioning deficits that hindered their learning process. Several causal models attempted to account for the underachievement related to ADHD by proposing that ADHD might be explained by a combination of the cognitive dysfunction model and motivation-based dysfunction models (Sonuga-Barke, 2005). Furthermore, Denckla (2003) has suggested that the relationship between ADHD and school performance could be mediated through different pathways, one cognitive (executive functioning) and one behavioural (classroom performance).

However, although a negative association between the disorder and academic achievement has been well documented, an interesting debate still surrounded the issue of

direction of effects. Did ADHD influence the level of academic achievement? Or did the combination of poor academic performance and another behaviour related aspect lead to the diagnosis of ADHD? Trying to answer these questions, some authors have considered that academic underachievement could represent a starting point in developing further ADHD symptomatology. For example, McGee (cited in Saudino, Rogers, Asherson, & Kuntsi, 2007) posited that inattention patterns and hyperactive/impulsive behaviours were the result of the lack of academic success and intolerant attitudes within the classroom. Furthermore, Merrell (2001) suggested that academic difficulties combined with the negative attitudes from significant others could cause inattention, disruptive behaviour and later conduct problems. A learned helplessness model was proposed which suggested that repeated academic failure could lead to a sense of helplessness, which might decrease attention and motivation and increase maladaptive behaviours (Greenfield Spira, 2005).

2.2.5. How does ADHD manifest within the family setting?

According to Barkley (2005), children diagnosed with ADHD do not exist in a vacuum. They occupy specific places within various social networks or systems, the most significant of these being the most immediate one, the family. The family context has been identified as critically important for several reasons. Firstly, according to NHS Quality Improvement Scotland (2007), children diagnosed with ADHD have poor and disrupted family relationships, low self-esteem or exhibit anti-social behaviour. Children usually raise the irritant factor within the family as they tend to leave everyone on edge because their behaviour is often unpredictable, erratic and inconsistent. Secondly, the diagnosis might have a serious impact not only on the child, but also on parents and siblings, causing

disturbances to family and marital function (Alizadeh, Applequist, & Coolidge, 2007; Barkley, Fischer, Edelbrock, & Smallish, 1990; Johnston & Mash, 2001). Thirdly, according to Kashdan et al., (2004) parents of children diagnosed with ADHD rated their family environments as less supportive and more stressful than the comparison groups. Frequently, parents found that family members refused to care for the child and that other children did not invite them to parties or out to play (Harpin, 2005). Lastly, the presence of a child with the diagnosis of ADHD was often linked to increased risk of parental psychiatric disorders, most commonly conduct problems and antisocial behaviour (e.g. Edwards, Howlett, Akrich, & Rabeharisoa, 2001), alcoholism (e.g. Pelham & Lang, 1999), affective disorders (e.g. Harpin, 2005) or learning disabilities (e.g. Swensen et al., 2003).

However, research into the relationship between ADHD and family functioning has yielded inconsistent findings. Some authors have suggested bi-directional influences with the behaviour of children influencing the behaviour of their parents, which in turn exacerbated the ADHD symptoms and potentiated the development of other comorbid conditions (Gupta & Singhal, 2004). Thus, parents who were experiencing affective and social difficulties perceived their child as showing more disruptive behaviour and their behaviour as more difficult for them to manage than was for parents without such problems. This in turn reinforced the parents' view that the child had inappropriate manifestations beyond the "normal" range.

Considering that few studies have investigated the multiple aspects of family functioning, it has been very difficult to determine whether parents' malfunctioning followed or preceded the child's inappropriate behaviour. However, taken together, the reciprocation of recursive loops between children's and parents' behaviours could lead to

even more dysfunctional parent-child relationships and poorer psychological functioning in the family environment (Kashdan et al., 2004). This possibility has highlighted the importance of assessing not only the child's diagnosis but also potential parental psychopathology.

2.3. The Construction of ADHD

Like many other childhood conditions, the discursive battle in the history of ADHD was littered with competing and contesting discourses. While the empirical research seemed to be ubiquitous, two interdependent fields of enquiry, medical and social, have dominated the debate. Since the aim of my study has been to clarify the current research in the field, what preceded this section was located within the medical model of disability.

However, not all the studies have focused specifically on the way ADHD was conceptualised. Many authors have presented considerations about the construction of disability in general or about the construction of other similar conditions like autistic spectrum disorder or learning disability. This section reviews ADHD from both biological and social paradigms, engaging in debates about the models' applicability and presenting their strong points and critiques.

2.3.1. The medical model of ADHD

By the beginning of the 20th century, the main approach to understanding disability arose from the medical or individual model involved with intervention and treatment of impairment. The medical perspective emphasised that ADHD was primarily a bio-medical problem which was said to reflect a neurological dysfunction in the prefrontal cortex of the brain (Barkley, 1998). ADHD symbolised "social death, inertia, lack, limitation, deficit and tragedy" (Goodley & Roets, 2008, p. 239). According to Imrie and Edwards (2007) and Marks (1999), handing oneself over to an expert and rehabilitation through medical treatment was seen as the sole hope for affected individuals and their families. The point has been made, as Kauffman (cited in Fornes & Kavale, 2001) considered, that the medical model could be interpreted as being synonymous with scientifically based practice, relying upon current evidence in genetics, brain imaging and pharmacology. In a field where empirical validity was increasingly valued, the proponents of the medical model enabled ADHD to be constructed through chemical imbalances and brain deficiencies, explanations that gave credence to the medical model conceptualisation.

Advocates of the medical model are at the pathognomonic end of the continuum, believing that there was a specific impairment that existed within children diagnosed with ADHD. This idea was in accordance with Smith's (2006) deficit-orientation perspective which referred to the attitudes of significant others who taught a medicalised approach of "repairing the irreparable individual" (p. 93). Professionals viewed their responsibilities for the instruction of these students as minimal and their descriptions often favoured ranking, sorting and diagnosing.

However, because of the overemphasised focus on the notion of individual deficiency, the medical model started to be highly criticised. Firstly, as Conrad and Schneider (1992) ascertained, understanding ADHD as an individual neurologic disorder robbed practitioners of the opportunity to appraise the impact of environmental influences on the diagnosis. Secondly, the medical model relied upon the concept of difference, focusing on what is lacking compared to an unquantifiable norm. The impairments that children experienced placed them along a continuum between normality and abnormality, which was not clear cut. In this scenario, according to Danforth and Kim (2008), individuals were being held responsible for their difference and ultimately became prisoners of their own condition. These critical arguments described the medical model as a personal tragedy theory that suggested that disability was some terrible chance event which occurred at random to unfortunate individuals (Oliver, 1996). Thirdly, as Marks (1999) argued, the advocates of the medical model often gave priority to the scientific knowledge and invalidated the subjective experiences. For instance, children were expected to accept the treatment they were offered, parents became dependent upon medical expertise and teachers found themselves de-skilled and disempowered. Similarly, some philosophers regarded psychostimulants like methylphenidate (Ritalin) as a technology on the borderline between treatment of ADHD and enhancement of the human trait. (e.g. Cole-Turner & Elliott, 1998). According to the authors, the medication was set to improve children's chances for success but at the same time it had potentially serious implications for notions of free will and personal responsibility.

2.3.2. The social model of ADHD

The Union of Physically Impaired against Segregation (UPIAS) was in the vanguard of those calling for an alternative model of disability. While impairment was defined as lacking part of all of a limb, organ or mechanism of the body, UPIAS conceptualised disability as something imposed on top of the impairments by the way in which people are unnecessarily excluded from full participation in society. The main assumption of the social model was that the problems faced by disabled people were the result of socially created attitudinal or physical barriers that can be reduced or eliminated by social change. According to Oliver (1996), disability consisted in all the restrictions imposed on disabled people, ranging from individual prejudice to discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to discrimination in arrangements. There was no direct causal relationship between impairment and disability. The key issue was not the individual, but the way various aspects of society responded to that individual.

According to Goodley (2001), society could create ADHD, representing the arbiter of disciplinary powers that (re)produce pathological understandings of different bodies and minds. In this sense, referring to children with ADHD, Timmi and Taylor (2004) presented a more specific example. The inability to concentrate attention on a task might represent impairment, but the lack of attention constitutes a disability, a socially determined situation which could be solved by offering greater educational provisions. The hyperactivity might be a biological fact, but the ways in which this reaction was understood and made

meaningful was a fact of social environment. Furthermore, symptoms of impulsivity might be constant throughout the world, but it was how they were being perceived that gave them meaning and defined the care of children worldwide. Therefore, as Danforth and Navorra (2001) ascertained, ADHD has been reframed as being a social and linguistic artefact cofabricated within the complex construction and contestation of social codes, norms and identities.

The social discourse surrounding ADHD could produce positive effects for both the affected individual and the larger socio-political context. The social model harboured a number of virtues in repositioning people with ADHD as citizens with rights and reconfiguring the responsibilities for "creating, sustaining and overcoming the condition" (Humphrey, 2000, p. 63). On the other hand, approaching ADHD as a social construct could be psychologically beneficial in improving children's self-esteem and building a positive sense of collective identity. As Smith (2006) has also ascertained, educators perceived students as whole and complex individuals and taught with the students' strengths in mind. Instead of questioning if students could participate in a class activity, teachers who emphasised the exogenous contributions to learning, thought about how students could be involved in the activity. They perceived themselves as responsible for designing instructional accommodations and calibrating their instruction to engage their students (Pearson, 2009; Shakespeare, 2005).

However, the social model has often been misunderstood, misapplied or even wrongly viewed as a social theory. By claiming to discuss the social construction of ADHD, many authors were doing nothing more than describing the influences of social factors in creating the debilitating condition. This aspect led to a number of fundamental

critiques mainly from positions within the model itself. For example, although Shakespeare (2005) has suggested that the model has had very little to say about the cultural elements of disability, the major criticism was based on the argument that advocates of the social model discussed disablement as if it had nothing to do with the physical body. Concepts like pain, medication or ill-health were completely avoided. According to Burry (2000), it might be very difficult to deny any causal relationship between illness, impairment and disability, a denial that was seen as coming from a more general and mistaken sociological tendency to leave the body out of account. In this manner, the social model functioned against the recognition of a treatable risk (e.g. Graham, 2008). This situation determined parents, teachers and other professionals to consider only the disabling environments and hostile social attitudes, ignoring the real burden of suffering borne by children who will ultimately remain unidentified and untreated. It was in this sense that Norwich (2004) argued that the social model of disability might be constructed as an antisocial model of disability or a radical sociology. It failed to come down from the clouds in useful ways for the common person who faced real problems and suffering.

2.3.3. Alternative models of ADHD

The most common erroneous assumption among professionals has been that they would have to choose between biomedical and environmental explanations for ADHD, due to the incompatibility of these explanations. As Cooper (1997) asserted, being locked into one particular regime of signification would only encourage the dismissal of certain items and forms of knowledge. Neither biological nor social models alone could answer the complex questions regarding the existence of ADHD. Parents, teachers or medical practitioners might accept a biological explanation for why children behave differently whilst also recognising that social factors are mainly responsible for making the difference debilitating. One way of conceptualising ADHD could not be fully understood without attention to the other, because whilst they could exist independently of each other, there are also circumstances where they interact. For instance, environmental circumstances of an interpersonal nature could shape the biological constitution, and organic factors might also influence the social outcomes of the individual. Only a synthesis of these perspectives could move forward the much-needed interdisciplinary dialogues and investigations to close the knowledge gap.

Taking account of these claims, the conceptualisation of ADHD as a bio-psycho-social phenomenon has gained widespread acceptance among researchers. For instance, Tate and Pledger (2003) have argued that the experience of ADHD is multi factorial and encompasses biological and social aspects that could not be disaggregated. More recently, Cooper's (2008) systematic-eclectic orientation employed elements from the medical and

social models and combined them in a coherent form to contend that ADHD is a bio-psycho-social construct requiring multidisciplinary intervention.

Conclusively, much of the debate has served as little more than a perceptual stumbling block that shifted attention away from the very real distress experienced by children and their families. A more interactionist framework could enable professionals to consider disability from different but related perspectives, without necessarily treating them as strict alternatives. As Goodley and Roets (2008) have argued, this approach to understanding ADHD seemed to reintroduce an ontological and epistemological view of impairment.

2.4. Teachers' knowledge and attitudes towards ADHD

Given that children with ADHD spend the majority of their time at school, teachers play a major role in reframing and determining impairments, being at the forefront of delivering care at every stage. More specifically, as Girio (2006) pointed out, a teacher might initially notice impairment, call attention to the difficulties and initiate an evaluation of a child's struggles. In other words, what teachers know and how they perceive ADHD could influence students' academic, emotional and social development.

2.4.1. Teachers' knowledge about ADHD

Studies examining teachers' knowledge about ADHD have typically involved questionnaires or surveys applied to relatively large numbers of teachers. It is important to note that the apparently incongruent results could possibly reflect methodological differences rather than contradictory findings. For instance, researchers have developed their own scales to measure teachers' knowledge (e.g. Eranga, Williams, & Kuruppuarachchi, 2011; Miranda, 2002; Rodrigo, Vereb & DiPerna, 2004). Without piloting the scales, it was unclear whether such instruments reflected the latest research advances or consensus in the field. Additionally, the ADHD knowledge scales were often adapted from parents' knowledge measures and had no published psychometric properties for the instruments when used with teachers (e.g. the ADHD Knowledge and Opinions Survey, Rostain, Power, & Atkins, 1993). Similarly, most surveys were based on instruments like Knowledge of Attention Deficit Disorders Scale (Sciutto, 2000a) that were initially designed for and administered amongst an American population. There has been no consideration of the cultural context when applied to samples of teachers with different nationalities. Moreover, very few studies have undertaken a differential analysis of the knowledge about causes, treatment or symptoms subscales (e.g. West, Taylor, Houghton, & Hudyman, 2005).

The results of these studies conducted in numerous countries like Canada, the Middle East, Australia, Europe, and Asia have shown that many teachers continue to possess myths about the ADHD aetiology. Common misunderstandings included the attribution of the disorder to poor diet such as preservatives, food colourings or aspartame

(e.g. Brook, 2000; DuPaul, Weyandt, O'Dell, & Varejao, 2009), excessive consumption of foods high in natural or processed sugar, exposure to fluorescent lighting, tar and pitch, insect repellents or an overabundance of yeast in the diet (Weyandt, Fulton,Verdi, & Kymberly, 2009). Many teachers believe that ADHD is not a real disorder but just an excuse for bad behaviour, poor parenting or a result of a variety of environmental pollutants (Ghanizadeh, 2009, Jaska, cited in Oim, 2004). Furthermore, although most teachers understand some of the key characteristics of ADHD, some of them still support myths related to the symptoms and diagnosis of the disorder. For example, some teachers believed that if a child could play Nintendo for hours, he probably did not have ADHD (e.g. Pfiffner, 2005), or that children with ADHD outgrew the disorder when they reach adulthood (e.g. Piccolo-Torsky & Waishwell, 1998).

Despite the findings of these studies showing that teachers have poor knowledge of ADHD, some researchers have presented a more positive view. Jerome and colleagues (1994), for example, found that American and Canadian teachers seemed knowledgeable about the biological and environmental factors related to ADHD. In the same direction, comparing United States and Sweden, Carlson et al., (2006) concluded that teachers from both countries believed ADHD to be the result of a genetic predisposition with a strong organic basis. Furthermore, Nur and Kavakci (2010) and Sciutto (2000b) found that teachers had significant knowledge of the primary symptoms of ADHD, such as distractibility and fidgeting. Other researchers found that more than 50 % of teachers believed that attention problems continue through adolescence, 80 % accurately reported that ADHD is more common in boys than in girls and 79 % recognised that students can have attention deficits without hyperactivity (e.g. Jerome et al., 1994).

Teachers' understanding of ADHD treatment appears limited. Results indicated that teachers had reasonable knowledge of characteristics and causes of ADHD but had limited knowledge of treatments for ADHD, its benefits and side-effects (Funk, 2011; Snider, 2003; Vereb & Diperna, 2004). Furthermore, Weyandt (2009) showed that general educators hold myths about ADHD treatment, considering vitamin therapy as being effective in treating the ADHD symptoms. The only study undertaken in Scotland was conducted by Akam, Thomson, Boytera, & McLarty (2009), revealing that Scottish students' and qualified school teachers' knowledge of the side effects of psychostimultants was particularly deficient.

More importantly, various results obtained in this field were consistent with the prediction that teachers' knowledge about ADHD could be culturally-bound. In countries with a long tradition of offering high quality medical care to all of its citizens, teachers might be more aware of the ADHD interventions and seek adequate information about the management of the disorder. For instance, Oim (2004) concluded that Estonian teachers showed more knowledge and understanding of ADHD treatment than Norwegian teachers. In Graeper's study (2008), Vietnamese teachers revealed lower levels of self-reported knowledge than did the American teachers. Curtis, Pisecco, Hamilton, & Moore (2006) found that American teachers regarded medication to be more acceptable, effective and timely than did participants from New Zealand. Similarly, research conducted by Carlson, Frankenberger, Hall, Totten, & House (2006) illustrated that Swedish teachers rated educational intervention as being more effective than did the American teachers, emphasising the latter's unconditional faith in medication.

2.4.2. Teachers' attitudes towards ADHD

In the field of special educational needs, several attempts that have been made to measure teachers' attitudes, with indefinitive results. As a consequence, the empirical basis of some published results has been very limited. The majority of studies have failed to integrate definitions, measurements, theoretical utility and behavioural referents. The diversity of definitions was in contrast to the obvious similarity of research procedures which were based mainly on collecting quantitative data. This paradox arose firstly from definitional attempts that confounded attitudes and knowledge. The few studies undertaken revealed that the same instrument was used for measuring both knowledge and attitudes, or knowledge included as one of the attitudinal subscales. For instance, Chew (2012), Ghanizadeh, Bahredar, & Moeini (2006) and Jerome et al., (1994) designed only one questionnaire to jointly assess teachers' knowledge and their attitudes towards ADHD. Without any clear distinction between the concepts of knowledge and attitude, the authors highlighted that teachers revealed a lack of sufficient knowledge and a low level of tolerance. As Kos (2004) observed, the majority of the items used in these studies were merely measures of ADHD knowledge, and no adequate assessment of attitudes was undertaken.

Hepperlen, Clay, Henly, & Barké (2002) used the Test of Knowledge about ADHD as an indirect method of attitude measurement and concluded that the attitudes of teachers towards children diagnosed with ADHD had a lasting impact on the academic self-efficacy within the classroom. Barbaresi and Olsen (1998) aimed to assess teachers' attitudes in

relation to their experience, but what they actually did was to measure the level of their existent knowledge.

The research in this area has at times been inconsistent mainly because the complex construct of attitude was equated with other different concepts. To say a researcher was measuring attitude was ambiguous, because what exactly was being measured was not specified. As a consequence, studies undertaken in this field usually have not specified their definition of attitudes. Firstly, investigations contained generalised assumptions which were derived from assessing only a small area of attitude. Focusing exclusively on teachers' attitudes towards the inclusion of students with ADHD, Changpinit, Greaves, & Frydenberg (2007) and Hodge et al., (2009) discovered that teachers' attitudes were less favourable about the inclusion of students with disruptive and inattentive behaviours that were difficult to manage. Conversely, Koss (2004) showed that teachers generally believed that children with ADHD should be taught in the regular school system. Ghanizadeh, Fallahi, & Akhondzadeh (2009) revealed that informing Iranian teachers about their students' ADHD did not influence their attitudes, which showed that symptoms of ADHD were more important than ADHD labelling.

There is a long history of support for the notion that attitudes are a combination of individual evaluative judgements about a given object that can be reflected in affective, cognitive and behavioural responses. According to Ostrom (1969), the affective component of attitudes includes favourable to unfavourable feelings, expressions of like or dislike, various emotional and physiological reactions. The behavioural component includes supportive to hostile actions, reflecting personal action tendencies, past actions, future intentions, and predicted behavior. The cognitive component includes desirable to

undesirable qualities, reflecting values and attributes assigned to the attitude object, beliefs about the object, characteristics of the object, and relationships of the object with other objects (including self) in hypothetical situations.

Although the idea that mental states may include various conceptually distinct components has been around for thousands of years, in the field of special education needs, measures that tap the cognitive, affective and behavioural aspects of attitudes have been very rare (Hoang & Dalimonte, 2007). That said, the only study that has focused on the tripartite model of the attitude content was undertaken in Australia by Anderson, Watt, Noble, & Shanley (2012). However, the online survey used by the authors requested participants to rate statements on a very confusing rating scale, where the meaning of the very positive/very negative interval labels might prove difficult to comprehend.

Other studies have defined attitudes as being simple opinions related to mainstreaming, social functioning or medication. For instance, Stormont and Stebbins (2005) pointed out that 68 % of teachers revealed negative attitudes by opining that too many preschoolers are placed on medication for ADHD. Claiming to examine teachers' opinions, Arcia and Fernandez (2002) concluded that teachers' attitudes towards ADHD are limited as they were not well prepared to meet the demands presented by this category of children. More recently, for Bussing et al., (2011), attitudes were represented by general opinions towards medications, education and information about the illness and treatment prescribed.

Additionally, many researchers have reduced attitudes to their cognitive dimension, focusing mainly on perceptions and beliefs. For example, Reid (1994) investigated special and mainstream teachers' perceptions about ADHD and concluded that specialist educators

were more tolerant of ADHD type behaviours. Similarly, Foy (1996) assessed that educators possessed beliefs that portray ADHD as a neurological based disorder which required treatment and medication. Couture, Royer, Dupuis, and Potvin, (2003) ascertained that teachers from Quebec and United Kingdom had predominant beliefs that were of an evidence-based medical nature. Kos (2009) revealed that teachers generally perceived ADHD to be a legitimate educational problem, with no conscious control from the individual. Lastly, Furnham and Sarwar (2011) investigated beliefs about the causes, symptoms and treatments of ADHD and concluded that teachers were poorly informed about the aetiology and treatment of the disorder.

2.5. Parents' knowledge and attitudes towards ADHD

The majority of studies in the field of ADHD knowledge and attitudes have been undertaken primarily among samples of teachers of children diagnosed with the disorder. The few investigations that focused on parents encountered the same theoretical and methodological flaws. For instance, as argued in the previous section, researchers also reduced parents' attitudes to the constitutive dimensions, employing different terminologies like beliefs, perceptions, expectations, attributions or schemata. These inconsistencies were generated mainly because it was usually difficult to provide a universal definition of human attitude or to differentiate between its cognitive, affective or behavioural elements. Under these circumstances, studies have attempted to shed light on these controversial issues by

focusing mainly on parents' cognitions and attribution for inattentive, impulsive and inattentive behaviour and their anticipated affective responses.

On the other hand, most concerns about parents' knowledge about ADHD have been based on quantitative surveys. The few studies conducted on this topic have only scratched the surface regarding parents' knowledge and chose to ascribe minor importance to the meanings and their everyday experiences of living with this condition. Furthermore, researchers have been mainly preoccupied with providing a general overview of parents' knowledge about different treatment approaches and have often showed a lack of interest in exploring fathers' knowledge and attitudes towards their children. Goodley and Tregaskis (2006) were exceptions in attempting to redress the balance by placing parental perspectives in the foreground of debates about the construction of ADHD.

2.5.1. Parents' knowledge about ADHD

Overall, the majority of studies focusing on parents' self-rated information about what causes the onset of ADHD symptoms has revealed that at times their knowledge was consistent with the evidence based research, whereas at other times their knowledge seemed to be derived from popular myths. On one hand, Freeman (1999) pointed out that the majority of parents were convinced that children's behaviour was relatively intentional, reflecting their personal characteristics. In many cases, parents attributed children's behaviours solely to genetics, a medical condition, inappropriate development or just "something within her or him" (DosReis, Mychailyszyn, Myers, & Riley, 2007, p. 637). On the other hand, assessing the self-rated ADHD knowledge among a sample of African-American parents, Bussing et al., (1998) revealed that parents were guided by a definition

of symptomatic behaviours which were either "normal" or something the child will outgrow, and thus, not in need of professional intervention. In the same way, Iranian parents from Ghanizadeh, Bahredar, & Moeini's (2007) study did not report ADHD as a result of biological and genetic vulnerabilities, associating the ADHD symptoms with curiosity and high intelligence. Furthermore, half of them ascertained that poor parenting practices and parental spoiling were the causes of ADHD. These findings were in line with studies undertaken in the United Kingdom (Sonuga-Barke & Balding, 1993; Wolraich, Wilson, & White, 1995) and the United States (Bussing, Gary, Mills, & Garvan, 2007) which showed that parents associated ADHD with poor diet, nutritional habits or lack of parental discipline.

Studies about parents' knowledge about symptoms and diagnosis of ADHD are extremely limited. Harwood (cited in Gidwani, Opitz, & Perrin, 2006) pointed out that Puerto-Rican mothers reported the child's behaviour as showing a lack of respect while Anglo mothers described the same behaviour as independent and full of curiosity. Similarly, emphasising the same cross-cultural differences, Weisz, Suwanlert, Chaiyasit, Weiss, & Jackson (1991) remarked that, when compared to American parents, Thai parents rated their children's symptomatologyas as less serious, less likely to be a source of concern, less likely to reflect innate personality traits and more likely to improve in time. However, although most parents were knowledgeable about some of the key characteristics of ADHD, some of them expressed the expectation that their daughters' manifestations were just a sign of being a "tomboy" and that the girls would eventually outgrow this and become more "lady-like" in the future (Bussing, Schoenberg, Rogers, Bonnie, & Sherwin, p. 239).

Studies have also indicated that professional guidelines and parents' knowledge about ADHD treatment were only partially congruent, with the greatest discrepancy in the role assigned to stimulants. Results have been conflicting, but overall, they suggested that parents had mixed views and information about stimulant medication. In many societies, the stigma or aversion towards medication could be sufficient to create ambivalence about treatment. For instance, Cohen (2006) showed that parents were initially reluctant to administer medication to their children due to their awareness of the negative side effects. Parents rated the non-medication treatment approaches, such as counselling and positive behavioural techniques as much more acceptable than medication treatment (e.g. Chen, Seipp, & Johnston, 2008). Other studies reported that parents were generally satisfied with the medication, perceiving the treatment as more beneficial than did their children (e.g. McNeal, Roberts, & Barone, 2000). However, as Bennett, Power, Rostain, & Carr (1996) pointed out, once the children received treatment for a longer period and parents became informed about the medication, they acquired a better understanding of the benefits and limitations of stimulants and showed more willingness to pursue the right medication for their children. As Marple, Kroenke, Lucey, Wilder, & Lucas (1997) discovered in the Multimodal Treatment Study of ADHD (MTA)[2], most of the parents who were initially

[2] *The MTA is a multisite study designed to evaluate the leading treatments for ADHD, including behavior therapy, medications, and the combination of the two. The study included nearly 600 children, ages 7-9, who were randomly assigned to one of four treatment modes: intensive medication management alone, intensive behavioral treatment alone, a combination of both or routine community care (the control group).*

disappointed at being assigned to the medication group and not the combined behavioural or behavioural treatment groups reported general satisfaction at the end of treatment. In this scenario, parents were caught in a balancing act, constantly weighing the experienced benefits of the medication on academic and social functioning against its serious negative effects on health and well-being (Hansen & Hansen, 2006).

2.5.2. Parents' attitudes towards ADHD

According to Slimmer (2004), parents' attitudes could have a significant effect on children's self-esteem and identity construction. This aspect is even more important since school-age students are at a relatively early stage of developing their sense of self and may be less able to rationalise their experiences. Despite this, a limited body of research has aimed to explore parents' attitudes towards ADHD in school age children. However, taking account of the tripartite model of attitudes, it is worth mentioning the number of studies that have investigated schemata, attributions and the feelings that children diagnosed with ADHD evoked.

Firstly, several studies have found that, compared to parents of children in control groups, parents of children diagnosed with ADHD made more negative attributions in respect of their children's misbehaviour (e.g. Gerdes, Haack, & Schneider, 2012, Johnston & Freeman, 1997). According to Arcia and Fernandez (1998), parents' attributions could be loosely classified as organic, congenital, and genetic. Children's behaviour was often interpreted as beyond parental control. As Freeman (1999), Chronis (2004), Harbone, Wolpert, & Clare (2004), Hansen and Hansen (2006) and Yeh et al., (2005) have also

highlighted, parents conceptualised ADHD as a biologically-based disorder of a relatively chronic and pervasive nature which was best treated with medication. In other words, a considerable number of parents established the official diagnosis and helped to construct the entity of ADHD as an illness.

These results are consistent with the widely adopted medical model. That is, with particular regard to ADHD, parents felt compelled to endorse the well-accepted professional perspective and indicated that ADHD-like behaviours were difficulties intrinsic to the children. As comprehensively discussed by Cohen (2006) and Singh (2004), in a culture of mother blame, mothers were desperately trying to do their jobs without a backlash of accusations. The meanings they attributed to health and illness, pain and suffering, body and identity, served the purpose of easing their guilt. For mothers who experienced their children's behaviours as pathological and dangerous, ADHD diagnosis shored up maternal instinct, proved maternal sanity and thereby reaffirmed the potential of the good mother. The authors argued that parents usually adopted a brain-blame narrative that ostensibly absolved them of personal blame for children's manifestations.

However, an interesting contradictory result was obtained by Wilcox, Washburn, & Patel (2007) who described Indian parents who refused the biomedical meaning and proved reluctant to consider their children's difficulties as an illness. In the United States and Ireland, several parents viewed their children as self-efficacious and as more likely to have a positive future (Lench, Levine, & Whalen, 2011). In comparison to mothers, fathers were more likely to endorse beliefs that were less evidence-based and perceived the symptoms of the condition as more transient than do mothers. On the basis of their attitudes, fathers were

categorised as either "reluctant believers" or "tolerant nonbelievers" (Chen, Seipp, & Johnston, 2008, p. 34).

Secondly, existing studies have revealed that parents expressed negative feelings and emotions towards their children who had been given a diagnosis of ADHD. According to Smith (2002), parents might move initially to stages of grief, denying that there was a problem and rationalising why there was not actually a problem. As Glatz (2011) and Hansen and Hansen (2006) have also explained, parents were plagued with feelings of pessimism, hostility, shame, denial, and guilt, being permanently concerned that someone would blame them for their child's problems. When confronted with the diagnosis of ADHD, the grief for the loss of normality developed. Some parents grieved over their child's future risks or others reacted to the alterations the family must make to accommodate the diagnosis (Barkley, 2005). In the next affective stage, parents struggled with the fear, the anger and the guilt of having a child who experienced so many difficulties, whereas others went through periods of disbelief, depression and self-blame. They often felt guilty that their children's ADHD was somehow their fault. Parents confessed that being stricter, demanding more, and forcing more discipline might have positively affected the awfulness of their situation.

However, the certainty of the diagnosis finally brought parents to the stage of acceptance. For instance, parents from Singh's (2004) study acknowledged that they felt happier and less anxious after the diagnosis was made and when their sons began taking medication. They probably experienced relief as the diagnosis enabled them to feel exonerated from the blame of poor parental skills and moved the focus to the child's brain. According to Norris and Lloyd (2000), parents even started arguing that they have the right

to drugs that could normalise their child's biologically dysfunctional behaviour. Nevertheless, the ADHD label brought with it a justification for their child's behaviour, release from the guilt and an active concern to source the best treatment possible for their child.

2.6. Collaborative efforts in the field of ADHD

"Interdisciplinary collaboration is an effective interpersonal process that facilitates achievement of goals that cannot be reached when individual professionals act on their own" (Bronstein, 2003, p. 299). In this scenario, as O'Keeffe and McDowell (2004) emphasised, teachers have a major role to play in the management and assessment of children's academic and behavioural problems. Furthermore, due to their permanent exposure to children in the classroom, they have been considered one of the most valuable sources of information. Parents' direct involvement in the learning environment of their young children could increase their academic achievement, having a beneficial effect on children's social skills and self-perception (Drolet, Paquin, & Soutyrine, 2006).

Teachers and parents are required to meet certain expectations that are strongly related to what they know about ADHD and whether their attitudes enable the interdisciplinary collaborative efforts. But teachers and parents are not functioning alone in the ADHD arena. They are operating within a system that includes an array of other significant professionals. The difficulties that arise due to ADHD are often complex, and co-management by families and professionals in both health and education systems is

required for optimal outcomes. "The complexity of ADHD requires co-operation among a number of professionals employed by different agencies and using a wide variety of techniques-in other words, a multi-modal, multi-professional and multi-agency approach" (The National Institute for Clinical Excellence, 2008, p. 24). However, although a large body of research emphasised the importance of the general collaborative process, very few outcome studies on interdisciplinary collaboration in the field of ADHD have been identified. The limited number of studies on this topic have presented co-operative relations in a negative and pessimistic manner with an almost exclusive interest in the diagnostic process and the psychiatric assessment.

2.6.1. Collaboration between parents, teachers and health providers

2.6.1.1. Parents, teachers and ADHD

The evidence from the few studies focusing on home-school relationships has suggested that parents have continued to experience dismissal of their own opinions as unreliable and have felt disempowered in their relationships to teachers (Runswick-Cole, 2007, Woodcock & Tregaskis, 2006). For instance, Hodge and Runswick-Cole (2008) pointed out that teachers often devalued parents' knowledge about the child and privileged the more accurate professional expertise. In Hodge's (2009) investigation, parents strongly agreed that, sometimes, educators were preoccupied more with the identification of syndromes rather than knowing better the individual child. Reid, Maag, Vasa, & Wright (1996) presented other stories which revealed a picture of a school system that was failing in its responsibility to ensure that support services and accommodation were available for students diagnosed with ADHD. Parents considered teachers as lacking knowledge about

ADHD and failing to recognise that the behaviour might be indicative of a disorder. At a macro level, several parents saw themselves as playing a necessary collaborative role in educating teachers and staff about ADHD and helping them to move to higher levels of problem recognition.

Similarly, in her cross-cultural study, Malacrida (2004) presented several case studies designed to illustrate the different complaints parents had in relation to the way in which ADHD was conceptualised by Canadian and British educators. Canadian mothers' stories indicated that teachers viewed ADHD as a medical condition and pressurised them to obtain assessment and medication. Canadian teachers had little interest in the problem of ADHD beyond simply asking to "get an assessment, get a Ritalin trial and get the kid on meds" (Malacrida, 2004, p. 68). On the other hand, British teachers were loathed to accept ADHD as a real diagnosis, thus making the access to support services and administration of any kind of non-disciplinary treatment extremely problematic for children and their families.

These aspects provided a glimpse into the lack of consensus about the status of ADHD among various professionals around the world, and between educators and medical practitioners who diagnose and prescribe treatment. Contradictory professional beliefs and attitudes caused a lot of confusion among parents. In this sense, participants in Dennis et al.'s (2008) study talked about "the disconnected encounters" (p. 25) due to a lack of continuity of care. As O'Keeffe and McDowell (2004) concluded, the absence of direct contact and contrasting conceptualisations about ADHD led to dilution or distortion of messages, as parents were relied upon to interpret and transfer information which was often complex in nature.

2.6.1.2. Teachers, health care providers and ADHD

According to Amstrong, cited in Hodge and Runswick-Cole (2008), co-operation usually involves an effective sharing of ideas and implies mutual respect, complementary expertise and willingness to learn from each other. However, as Cooper (1997) commented, the effective collaboration between teachers and medical practitioners was often hindered by misunderstanding and misinformation from either party. The medical and educational approaches pursued different goals and utilised different criteria when dealing with an individual diagnosed with ADHD. For instance, many teachers focused less on labelling the problems and more on providing an educational plan. According to O'Keeffe and McDowell (2004), a significant proportion of teachers refused to recognise the biological nature of ADHD, which led to the reassurance that children will grow out of ADHD and a misinterpretation of the child's behaviour as deliberate. Secondly, health care providers' distorted ideas about what goes on in schools and what can be done educationally to help children with ADHD could be similarly counterproductive. Medical practitioners preferred to use internationally agreed criteria to confirm or rule out specific diagnoses around which to plan treatment (Salmon & Kirby, 2009). Insufficient knowledge about current classroom conditions, available resources and support influenced their perceptions about what is achievable within the educational setting.

Trying to understand these processes, Cranstoun et al., (1988) assessed the attitudes of both teachers and medical practitioners and found that each group accused the other of arrogance, absence of follow-up and a lack of knowledge of the other's field of work. These findings were in line with more recent conclusions drawn by O'Keeffe and

McDowell (2004) who pointed out that Australian teachers described health care providers' input as unrealistic, impractical or arrogant, with professionals being too busy or unable to coordinate time for phone calls and meetings. Similarly, in Dennis et al.'s (2008) investigations, teachers reported that they needed more recognition of their authority from school psychologists and psychiatrists. When asked for suggestions as to how medical practitioners could better assist schools with the management of children diagnosed with ADHD, teachers spoke about having more direct contact with medical staff, additional advice in relation to practical hands-on tasks, provision of jargon free written reports, and education for teaching staff about the disorder and its treatment. Reflecting the inter-professional tension, one teacher advised the educational psychologist to be "more accessible to subject teachers and to give more time to counselling and less to diagnosis" and another commented that "sometimes it is the teachers that need the help, it is not always just the kids, you don't know how some of these children make us feel" (Maras, Redmayne, Hall, Braithwaite, & Prior, 1997, p. 47).

However, despite the difficulties encountered by teachers and medical practitioners in establishing an effective collaboration, attempts were made to construct organisations, models of delivery and coalitions which aimed to be compatible with both the health and educational cultures. The intention of these synergistic projects was to improve the assessment and management of ADHD by optimising the communication among parents, schools and health care providers. The ADHD Decision Tree, The Clinical Path Model and Family-School Success were also proposed to improve the family and educational functioning of students who met criteria for ADHD combined and inattentive types within American schools. Magyary and Brandt (2002) explained how the diagnostic process

provided specific tasks for the parents, educators and the clinicians. Oppenheim (2004) and Power et al., (2012) described how these programmes were implemented to address collaboration within the school and the partnership with outside agencies. Needs assessment teams were formed in order to facilitate the consultation between American teachers and school psychologists about behaviours that raised concern, helping them to get more specialised skills and to find shared solutions to the problems exhibited. Furthermore, some American schools have integrated health-related services and have started to provide medical and social assistance to families of children with ADHD. In Romania, Danciu (2011) described the implementation in 8 primary schools of a multi-disciplinary approach that was designed for pupils diagnosed with ADHD and their parents. However, the collaboration between the psychologists, doctors, kinotherapists, ergotherapists, social assistants, parental counsellors, parents, other medical personnel, teachers and social activists was nothing more than a medical intervention aimed at eliminating the deficit.

2.6.1.3. Parents, health care providers and ADHD

ADHD can be puzzling for professionals and for parents alike. In spite of the importance of multidisciplinary teams, very few studies have addressed collaboration between parents and health providers in helping students with ADHD. Oppenheim (2004) identified important differences between families and medical practitioners in their understandings about ADHD and in their perception of what others know or believe.

Studies focusing on the relationship between parents of children with ADHD and medical practitioners have shown that parents have felt excluded, but at the same time the

burden of dealing with the ADHD symptoms fell almost exclusively upon them. Many researchers have echoed the concerns and demands of parents, namely the negative effects of drugs or the over-medicalisation of ADHD. Not only did families feel let down, they were also openly challenging the medical expertise, refusing to accept that often the doctor knows best. For instance, Runswick-Cole (2007) and Woodcock and Tregaskis (2006) presented evidence that parents considered professionals to be reluctant to share information with them about their children and often avoided discussing the complexities of the issues being presented. Indeed, one parent in Runswick-Cole's (2007) study explained that she had published a book on ADHD in order to make professionals aware of the fact that she knew more about ADHD than they did. On the other hand, many parents challenged the medical profession on their own ground, using a medical perspective. Research by Norris and Lloyd (2000) illustrated that parents from the United States and Australia were not afraid to show their anger with the medical profession for failing to diagnose ADHD or to prescribe drugs. Participants argued that their child should have the right to the drugs that would ultimately normalise their child's biologically dysfunctional behaviour.

In this sense, a group of professionals came together to create a wide support and information network for Scottish children and families affected by ADHD. "Attention Fife-A Holistic Approach to Attention Differences" aimed to encourage self-help, raise awareness, share experiences of positive options and empower parents to make informed choices about ADHD. In the United States, in response to the frustration and sense of isolation experienced by parents and their children with ADHD, a national resource centre and a family membership organisation were founded. Having

enrolled approximately 14,000 parents and 1,200 professional members, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) hosted support groups, peer public education forums and parent-to-parent training aimed at improving the lives of people affected by ADHD. The School Health Initiative for Education *(*SHINE*)* founded by LeFever in 2002, instituted a mechanism for systematic exchange of information between physicians, psychologists and parents, dedicated to improving the mental and physical health of school children in eastern Virginia.

However, as Malacrida (2004) has pointed out, although the various inter-disciplinary networks were of an undoubtable value, they did not compensate for the deficits in the partnership model. This idea was even more important since, according to Norris and Lloyd (2000), rather than fighting for the rights of children with ADHD, these coalitions served the interests of the press, drug companies or ADHD experts. These experts often encouraged coverage of their own concerns. Organisations throughout the world seemed to remain committed to a biomedical approach to ADHD that might close off therapeutic avenues other than medication or, on the contrary, open up an arena for action in which social structures were often a target for critique (Edwards, Howlett, Akrich, & Rabeharisoa, 2012).

2.7. Key points of the literature review

- ADHD is one of the most common reasons children are referred to mental health clinics with estimated prevalence rates of 5% of schoolaged children (Barkley, 1998). The essential feature of ADHD is "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than typically observed in individuals at a comparable level of development".

- The aetiology of ADHD is probably multifactorial and composed of genetic and environmental factors. There's no specific test for ADHD. However, when it comes to treating children diagnosed with ADHD, the literature has supported the use of medication and other non-pharmacological intervention.

- Various authors have claimed that a diagnosis of ADHD could have a profound effect on many aspects of children's' school performance and family functioning.

- ADHD is a modern phenomenon that has sparked virulent debate in recent years in terms of its conceptualisation. In the research literature, ADHD manifested as either a medical, social or bio-psycho-social construct and controversies result because of an intellectual "territoriality" (Bryant et al., 2003), characterised by struggles over whose knowledge is of most worth.

- Despite such widespread prevalence of ADHD, little is known about the level and sources of knowledge regarding ADHD among parents and teachers. Studies examining teachers' and parents' knowledge and attitudes towards ADHD have encountered similar methodological issues and limitations. Depending on the instruments employed, research in the field yielded inconsistent results. For instance, some parents and teachers were found to be extremely knowledgeable and positive about ADHD, the special difficulties it creates for children, and effective strategies for helping children with ADHD succeed. Many other, however, were seen severely lacking knowledge about the causes, symptoms and treatment of ADHD, possessing myths and unsupportive attitudes.

- The limited number of studies on this topic have presented collaborative relations in a negative and pessimistic manner with an almost exclusive interest in the diagnostic process and the psychiatric assessment. Collaborative efforts between parents, teachers and medical practitioners seemed to remain committed to a biomedical approach to ADHD that places the locus of responsibility for disability on the individual, requiring that the individual adjust and adapt to society as it is.

3. Research methodology

3.1. Introduction

According to Hughes (1990), every tool or procedure is inextricably embedded in commitments to a particular view of knowledge and a conception of the nature of existence. Ontological and epistemological assumptions are addressed explicitly since they feed into the way in which the research was designed and conducted.

This study had two principal aims. Firstly it tried to explain the patterns of teachers' and parents' knowledge and attitudes towards ADHD. Secondly, the research was concerned with exploring the meanings that teachers and parents attached to certain experiences. The mixed-methods design rejected the incompatibility thesis and claimed that different research traditions, rather than being incompatible, could also be mixed into a more eclectic research paradigm.

In terms of ontology, the mixed methods approach explicitly acknowledged the multi-faceted nature of phenomena. Initially, the reality was seen in terms of causes and effects and generated predictive knowledge. The underlying assumption was that human knowledge and attitudes were often caused by various internal or external factors. This was a more realistic position which considered that the social world had an existence which was as hard and concrete as the natural world. By collecting quantitative data, this study aimed to generate valid results and to advance objective knowledge about the attitudes and knowledge that teachers and parents possessed. Truth and meanings existed apart from the operations of the consciousness (Crotty, 1998).

However, the administration of questionnaires could limit the understanding that they produced. While living in an objective universe, participants were also able to creatively construct and negotiate subjective personal and social universes that may or may not approximate objective reality (Blaikie cited in Crotty, 1998). According to Pring (2000), meanings were imposed on the object by the subject with a preservation of the essential subjectivity of the private worlds of the teachers and parents. Semi-structured interviews were considered to be more appropriate for the exploration of the perceptions and opinions of participants regarding complex and sometimes sensitive issues, allowing the exploration of the multiple realities of the individuals. In this way, knowledge was viewed as being both constructed and based upon the reality of the world participants experienced and lived in (Biesta, 2010).

As Johnson and Onwuegbuzie (2004) and Morgan (2006) concluded, a mixed-methods approach could recognise the existence and importance of the natural or physical world as well as the emergent social and psychological universe that included language, culture, human institutions and subjective thoughts. In this approach, there was no problem with asserting both that there was a single real, observable and measurable world and that teachers, support staff and parents had their own unique interpretations of that world. The merits of mixed-method design consisted in the possibility of combining objective observation and precise measurement with interpretation of subjective experience and constructed social realities.

The research methodology employed a multi-modal approach in order to gain insight and to examine in more depth teachers' and parents' knowledge and attitudes towards ADHD. According to Lieberman (2005), Mahoney and Rueschemeyer (2003) and

Mastenbroek and Doorenspleet (2007), central to the plea to mix methods was the belief that quantitative and qualitative methods complement and strengthen each other. Considering the fact that both quantitative and qualitative analyses suffered from certain specific shortcomings, a mixed methods design aimed to combine the advantages of both methods in one single framework. As in many other cases, the goal of mixing, in addition to the complementarity of the findings, was the expansion and elaboration of our understanding of ADHD (Onwuegbuzie & Leech, 2004).

The study aimed to collect both quantitative and qualitative data in order to make the results more valuable and to advance the knowledge about ADHD issues in childhood. "Using more than one source of information and being systematic and careful in your evaluation will help to ensure that your findings are even more credible" (Miles and Gilbert 2005, p. 175). Besides, using more than one method of data collection allowed the pursuit of the multiple realities of the participants, enabling not only the opportunity to gain an insight about the knowledge and attitudes of teachers and parents, but also to examine the diversity among participants.

Overall, this study employed a mixed method design based on a concurrent nested approach with a sequential analysis (Creswell, 2003). As Lieberman (2005) argued, one of the most important motivations for developing the nested design was the desire for it "to combine the strength of large studies (external validity) with the strengths of small case studies (internal validity) resulting in an improvement of the quality of concepts and measurements" (p. 436). Therefore, the first step of the study was to collect quantitative data from a relatively large sample of teachers and parents. This preliminary analysis

provided insights into various attitudinal and knowledge patterns and identified plausible factors that might explain their positions.

Another aim of this research was to study the phenomenon in detail along with making standardised and systematic comparisons in accounting for variance. The study used a standardised questionnaire with the aim of obtaining valid, reliable and accurate measures of complex elements like attitudes and knowledge. The rationale behind this choice was based on the assumption that generally knowledge and attitudes were not directly observable and their existence could be only inferred from overt responses or indicators (Himmelfarb, cited in Eagly & Chaiken, 1993). In this way, the questionnaire was justly used to measure a verbal response to a symbolic situation. Rather than relying on responses to interviews, questionnaires were selected as the best available method to collect original data from a population too large to observe directly or to make descriptive assertions about (Kleynhans, 2005).

On the other hand, administering only questionnaires would offer limited insight into the research topic. The responses from the questionnaire might have been distorted by socially desirable responding, psychological defenses or various response biases. Teachers and parents might be unable to answer questions about their personality and they might lie or mislead the researcher. Furthermore, beliefs, values, opinions and attitudes are notoriously difficult to quantify. In this scenario, a deeper understanding of the phenomenon required a more exploratory methodology. The subsequent utilisation of semi-structured interviews allowed the observation of the participants' answer to an unstructured situation. Nevertheless, the research emphasised the importance of the subjective meanings that participants attributed to specific topics. It was expected to enter, in an emphatic way,

the living experience of a person or group being studied (McLeod, cited in Silverman, 2005). The two aforementioned methods were not seen as conflicting, but as complementary. As Mastenbroek and Doorenspleet (2007) highlighted, statistical methods were at their strongest in establishing the former, while interviews were at their best in establishing the latter. More specifically, the analysis of the questionnaire responses added to the qualitative analysis by guiding the further selection of a small number of representative cases of teachers and parents. In this way, the quantitative analysis influenced and facilitated the interpretation of qualitative data, addressing more appropriately the reality of teachers', support staff and parents' knowledge and attitudes towards ADHD. However, as Grey (2004) pointed out, collecting both quantitative and qualitative data might be subject to a whole host of biasing factors, many of which are the product of normal cognitive processing. The subjects' knowledge and attitudes were very delicate issues beyond direct observation and for this reason the assertions made were interpreted with caution.

3.2. Theoretical foundation of the study

Firstly, in the analysis of the research data, the experiences of parents, teachers and support staff will be explored, drawing on the work undertaken in the field of disability by Fulcher (1989), Goffman (1963), Oliver (1996) and Shakespeare (1995). The analysis will attempt to give meaning to participants' lived experiences and to use the social and medical model of disability as two frameworks that highlight the ways in which disability is approached and understood. In this sense, Olkin (2002, p. 113) compares these two models along 6 dimensions: the meaning of disabilities, moral implications of disability, sample ideas, goals of intervention and benefits and negative effects of the model (See Table 1).

Measure	Medical model of ADHD	Social model of ADHD
Meaning of disability	**A defect in or failure of a bodily system that is inherently abnormal and pathological**	**ADHD is a social construct. Problems reside in the environment that fails to accommodate children**
Moral implications	**A medical abnormality due to genetics, bad health habits, childrens' behaviour**	**Society has failed a segment of its citizens and oppresses them**
Sample ideas	**Clinical descriptions of patients in medical terminology. Isolation of body parts**	**Nothing about us without us or Civil rights, not charity**
Goals of intervention	**Cure or amelioration of ADHD to the greatest extent possible**	**Political, economic, social, and policy systems, increased access and inclusion**
Benefits of model	**A lessened sense of shame and stigma. Faith in medical intervention. Spurs medical and technological advances**	**Promotes integration of ADHD into the self. A sense of community and pride. Depathologising ADHD**
Negative effects	**Paternalistic, promotes benevolence and charity. Services for but not by children diagnosed with ADHD**	**Powerlessness in the face of broad social and political changes needed. Challenges to prevailing ideas**

Table 1. A Comparison of the Medical and Social Models of ADHD.

At the macro level, different understandings about what constitutes a disability and its effects could highly influence attitudes towards disabled people and their lives. For

instance, the medical discourses on disability could shape a view of disabled people as having limitations or weaknesses. As Fisher and Goodley (2007) have ascertained, the medical model postulated that ADHD is constructed as forms of individual pathology whilst charity discourses might portray the diagnosis as an object of pity or in need. Rather than understanding disability as a matter of medical or charitable approaches, the proponents of the social model reconceptualised disability as the result of social processes, cultural practices and political structures. At the micro or personal level, disabled people are often stigmatised and labeled as a result of the knowledge, attitudes and understandings that others hold about them. This aspect could lead to a wide range of structural, environmental and attitudinal barriers that stop people with disabilities from being included as equals. The social model of disability will be drawn upon to illustrate how issues of disabling barriers and internalised oppression affect the lives of children diagnosed with ADHD. These theoretical models will open up more possibilities to explore how the participants find the space to conceptualise their circumstances and alternatives to these, but the very way in which data is collected could position parents, teachers and support staff as "architects of their own identity constructions, which may or may not follow dominating societally-formed plots, scripts and stories" (Fisher & Goodley, 2007, p. 69).

Secondly, this is the first study to employ the theory of the anthropologist and sociologist Arjun Appadurai to understand the conceptualisation of ADHD, and as such has an idiographic aim (Livingstone, 2003), seeking to determine, through comparisons, what is distinctive about each country. In order to compare the results obtained in Scotland and Romania, I will draw particularly on Appadurai's theory of culture and cultural identity. His theory will help to shed light on the underlying social contexts that could shape or even

exacerbate the conceptualisation of ADHD, considering how the range of variations in definitions of ADHD might differ from one cultural context to another (Hunsinger, 2006). In other words, Appadurai's (1996) theoretical framework could provide a useful lens for making sense of the data obtained from this study. His concepts will be useful as an analytic tool for several reasons, in that ADHD could be reconceptualisd, perhaps radically, taking into consideration the specific variables that have influenced the cultural snapshot of the condition. As Lomborg (2012) commented, "using the idea of a photographer or painter wanting to capture a landscape we begin to build a sense that depending on innumerable variables, the picture will change" (p. 54).

Appadurai's (1996) idea of scapes as being different flows, with irregular, fluid borders that inconsistently overlap with each other might represent more than a metaphor when thinking about ADHD. In his book *Modernity at Large*, Appadurai (1996) defined the term scape as being a building block of imaged words that are constituted by the historically situated imaginations of persons and groups spread around the globe. The cultural logic of globalisation was described as a series of imaginary landscapes made of ethnoscapes, mediascapes, tehnoscapes, financescapes and ideoscapes. Ethnoscapes were represented by the landscape of persons who constituted the shifting world we live in (e.g. tourists, immigrants or refugees). The idea of technoscapes suggested that technology, both high and low, both mechanical and informational is now moving at high speeds across various kinds of previously impervious boundaries. The rise and dominance of new forms of science (e.g. biology, medicine, psychiatry, anthropology, psychology, sociology, and pharmaceutical innovation) led to the pre-eminence of certain models in the ways people's suffering, pain and distress are commonly constructed by researchers and clinicians. The

commercialisation and commodification of childhood determined an increase in consumer goods targeted at children and the creation of new commercial opportunities in childhood, for example the parenting industry and the pharmaceutical industry and more specifically the approval of Ritalin for the treatment of children. The deposition of capital (e.g. currency markets, stock exchanges) was incorporated within the Appadurai's financescapes. Media scapes were a form of disseminating the information (e.g. newspapers, TV) providing large complex repertoires of images and narratives to viewers throughout the world, in which the world of commodities and the world of news and politics were profoundly mixed. By generating media-fueled panics about ADHD and by the marketing of images of children as troubled and troubling, we created a scapegoat generation held responsible for a whole host of social ills (Males, 1999).

Lastly, Appadurai defined the ideoscapes as concatenations of images that are often directly political and frequently related to the ideologies of states and the counter ideologies of movements explicitly orientated to capturing state power or a piece of it. In this context, there may be specific political elements which influenced the formation of social representations of disability within Romania and Scotland: political regime, transition characteristics, changes in social policies, changes in the legislation for persons with disabilities, the evolution or decline of the national economy, political orientation of government, adherence to the European Union process, changes in the education system or the process of globalisation. Influences which were once considered deeply imbedded and immovable, such as people, media, images, technology, capitalism, monetary resources, ideologies, these were now becoming fluid and were being transported (sometimes simultaneously) on a global scale.

The theory of scapes offers a useful way of considering the multiple and interconnected sites in which ADHD is produced and perpetuated, influenced by the "historical, linguistic, and political situatedness" (Appadurai, 1996, p. 33) of all the actors involved in childrens' lives. This is the reason why Appadurai's theory was selected to analyse the cross-cultural data, considering that the economic, political, and historical elements absent from other approaches were integral aspects of his work on culture. In this sense, starting from the assumption that ADHD must be situated in time and space, the data analysis will be based on the various scapes employed by parents, teachers and support staff in order to explain why the conceptualisation of ADHD varied or was consistent within both cultural contexts. Indeed, according to Jones, Brophy, Moore, & James (2007), when the place of disability is considered, discursive and material effects of history, culture and power converge, along with the embodied and the experienced sedimentation of physicality and other restrictions imposed in conditions not of subjects' choosing.

Although all the four scapes could influenced the construction of ADHD in a slightly different way, the interpretations of participants' narratives will aim to sketch a framework of how these ethnoscapes, mediascapes, technoscapes and ideoscapes were at work in these individuals' lives. Therefore, the way in which ADHD was constructed will depend on what scapes parents and teachers saw and how they interpreted them. More specifically, parents, teachers and support staff might experience various and different scapes in the process of caring for a child diagnosed with ADHD. With the aim of generating an understanding of the knowledge and attitudinal patterns, these scapes will be explored and described based on participants' discourses and narratives. In the study, the theoretical framework of these overlapping disjunctive flows will be applied, as the scapes

could act as an apt metaphor for the complexity of ADHD and the positioning of parents and teachers within it. However, according to Lomborg (2012), Appadurai described ethnoscapes, mediascapes, financescapes, technoscapes, and ideoscapes, but there is no need to be limited to these, as they are in this usage simply tools for thinking about multiple sites of meaning through networks and mapping.

3.3. The research sample

In contrast to large longitudinal quantitative research, sampling in this mixed-method project was purposeful rather than random in nature. Samples were drawn to reflect an emphasis on information-rich cases that elicited an in-depth understanding of ADHD (Jones, Torres, & Arminio, 2006).

3.3.1. Selecting the sample of parents of children diagnosed with ADHD

This cross-cultural research involved the comparison of samples from different cultural populations. The type of sample selected was dictated by the research questions and objectives. The first step in achieving data equivalence was to carefully take into consideration the sampling frame comparability which referred to whether the samples drawn from different cultures paralleled each other and could be established pre-data collection. In this project, functional equivalence of the samples was considered.

Recruitment of children diagnosed with ADHD and their parents was based on a convenience sampling performed in two cities located in Scotland and Romania. The

rationale for choosing those sites was based on the fact that both locations revealed an interesting pathway of over-recognition and over-treatment of ADHD compared with the national averages. The population sample included parents of school-age children diagnosed with ADHD drawn from one outpatient pediatric clinic in Scotland and a child and adolescent mental health centre (CAMHC) in Romania. The electronic data bank allowed rapid and efficient retrieval of information accumulated from children and adolescents with a clinical diagnosis of ADHD. For each patient, the data bank held the personal details plus the most important demographic information. In order to identify the sample of children diagnosed with ADHD, clinicians who assessed and diagnosed were firstly presented with the numerous inclusion and exclusion criteria. Only the members of the existing clinical care team had access to patients' records in order to identify potential participants and check whether they meet the inclusion criteria. The direct care team ensured that, as far as possible, information was only disclosed with the patients' consent.

Firstly, children had to meet the diagnostic criteria for ADHD, irrespective of the subtypes (inattentive type, hyperactive/impulsive type or combined type). Furthermore, the children's ages had to fall between 6 and 11 years old and they had to be enrolled in a mainstream primary school. This chronological interval was chosen mainly because ADHD is often diagnosed during primary school years, between 6 and 11 years old. During this time, the symptoms of ADHD are apparent and clear, as the rules and routine of a school make it easy for the symptoms to come to the fore. It is unusual for ADHD to be diagnosed in pre-school children as they are commonly active, and this cannot be counted as abnormal behaviour. On the other hand, if an adolescent exhibits extreme hyperactiveness, this could

be a signal of another medical condition already persisting and negatively affecting his/her development.

Only male patients were recruited to take part in the research. The prevalence of ADHD among males is thought to be 4 times that of females. The boys diagnosed with ADHD are more likely to be hyperactive and explosive than the girls with the same condition, being more often recognised and treated by physicians because their problems are more evident and severe. Indeed, analysing the medical and school records, several researchers claimed that the male sex was associated with a threefold increase in risk of ADHD (Barbaresi, Katusic, & Colligan, 2002) with boys being 3 times more likely than girls to develop the condition (Cunningham, Pettingill, & Boyle, 2004). In this context, the inclusion of girls diagnosed with ADHD could have caused a significant decline in the representativeness of the sample, producing a potential source of measurement error and providing misleading results. However, future research could explore if the knowledge and attitudes towards boys diagnosed with ADHD are the same as for girls with the same clinical manifestations.

In order to realise an adequate equivalence of the samples, the cohort consisted of white British/Romanian male patients with English/Romanian as the first language. Moreover, the study focused only on collecting data from the biological mothers of children diagnosed with ADHD. This decision was made taking into consideration the scientific literature where parenting was conceptualised as a more discretionary role for fathers than mothers (Costigan & Cox, 2001). Mothers spend the most time with the child and know his or her behaviour the best. Furthermore, there was a general sense that fathers were more difficult to recruit into parent-child studies, they were perceived as being less

available than mothers and more unwilling to participate. In light of this previous neglect and underrepresentation, increased attention to the role of fathers could be a welcome addition to follow up research.

In terms of the exclusion criteria, children diagnosed with ADHD and any major sensorimotor dysfunction (e.g. paralysis, deafness, blindness), evidence of a neurological disorder (e.g. epilepsy), or history or evidence of psychosis or intellectual disability were not selected for this study. However, since children diagnosed solely with ADHD have become an increasing rarity, other less severe comorbidities were not taken into account. In depth examination of the phenomenon of comorbidity could be an overambitious goal considering that attention (e.g. ADHD), emotional (e.g. anxiety), behavioural (e.g. conduct disorder) and learning disorders (e.g. dyslexia) significantly overlap with each other across a continuum of frequency and severity. However, further studies might emphasise the importance of investigating how knowledge and attitudes vary according to type, severity and comorbidities of ADHD.

Furthermore, the sample excluded school-age children diagnosed with ADHD who attended a special school or were not enrolled in any form of education. Girls with a diagnosis of ADHD or children from ethnic origins other than white British or Romanian were also not included. There was also no focus on children diagnosed with ADHD placed in foster care or with an absent biological mother at the time of the investigation.

Lastly, the level of prescribed medication, alone or in combination (e.g. methylphenidate, atomoxetine, clonidine, dextroamphetamine, bupropion and/or desipramine) could not be determined prior to this study. One of the reasons was the fact that psychostimulants like Ritalin are prescribed in Scotland while in Romania they are

rarely used under this branding. Secondly, some children received medication, others received medication in combination with other forms of therapy, others undertook only cognitive behaviour therapy or anger management while several children were not medicated at all. Considering these issues, the selection of parents was not restricted according to the number of years or type of treatment received by their children. A new investigation could look specifically at parents' and teachers' knowledge and attitudes towards children with various medication backgrounds.

Of the 250 children in the Scottish sample and 191 children in the Romanian sample, 50 were randomly selected to participate in the project. A simple random selection was undertaken. The research gave each participant an equal chance of being chosen. Random numbers generated by Excel were used to select the required sample. Since recruitment for the study took place through local child psychiatrist/paeditrician, parents were initially contacted by phone or the study was mentioned during their regularly scheduled visit. All 50 mothers from each country gave their consent to take part in the research.

3.3.2. Selecting the sample of teachers and support staff

Both samples of teachers and support staff were drawn from regional and socioeconomically diverse major regions within the two countries. Since in Romania and Scotland children start and finish primary school at different ages, the age intervals were matched as follows:

Scotland:	**Romania:**
Primary 3 (aged 6–7)	Primary 1 (aged 6–7)
Primary 4 (aged 7–8)	Primary 2 (aged 7–8)
Primary 5 (aged 8–9)	Primary 3 (aged 8–9)
Primary 6 (aged 9–10)	Primary 4 (aged 9–10/11)
Primary 7 (aged 10–11)	

To identify and recruit participants, comprehensive lists of teachers, names and school addresses were obtained from the online database from each of the two sites. A total of 41 primary schools were contacted in Scotland. Of the initial sample, 19 principals said no and 11 never replied even after two phone calls. Various reasons were given for not participating (e.g. busy time of year in the school, staffing changes, headteacher about to retire, a very small staff required to undertake a huge amount of work involved in report writing, staff appointments, finance planning, or no reason was given at all). Therefore, 11 primary schools participated so that the Scottish sample consisted of 72 class teachers (P3 to P7) and 48 support staff. In Scotland, the selected group of support staff was represented by support workers, support for learning assistants, and classroom assistants.

49 primary schools were contacted from the list provided by a specific council in Romania. 18 schools never replied and 15 schools opted out for the following reasons: too many new teachers, other demands in the school, the school was focusing on academics and standardised assessment or the teaching body was protesting about the ever-increasing amounts of paperwork. Therefore, the convenience sample obtained from Romania included a cohort of 16 schools consisting of 86 class teachers (P1 to P4) and 57 support staff. The Romanian sample of support staff was exclusively constituted from classroom assistants.

According to the OECD Review of the Quality and Equity of Education Outcomes (2007), the teacher gender split continues to be heavily biased towards women, with around 93 % of primary teachers in Scotland being females. Figures on recruits suggested that female teachers coming into the profession outnumber male teachers 10 to 1. Similarly, Bîrzea et al., (2004) published a national report and concluded that, as in many other countries, the proportion of Romanian female teachers was higher than that of male teachers, with 75.5 % of the staff working in primary schools being females. Therefore, in the light of the declining proportion of men in teaching, only female primary school teachers and support staff were included in the study. Future research might focus on male teachers' knowledge and attitudes towards ADHD and how their feelings, cognitions and behaviours differ from those of their female colleagues.

3.3.3. Critical reflections on the research sample

This study aimed to explore the knowledge and attitudes of 100 parents and 263 teachers and support staff. This sample size allowed the subsequent statistical analysis and the investigation of the psychometric properties of the instrument. Participants showed a range of variability on the principal constructs that permitted a meaningful hypothesis interpretation. However, participants' recruitment was a time consuming process mainly because several types of approval had to be secured. Parents, the National Health Service, the local Research and Development Office and the clinical ADHD multi disciplinary teams had to consent. The local authority and the headteacher for each school were contacted in order to facilitate the meetings with the teachers. Even when parents and teachers decided to take part in the study, completing the questionnaire proved to be a complex and laborious task which in many cases required additional verbal explanations. Taking into consideration the high but slow response rate, the size of the sample was very difficult to expand since this aspect would involve tangible costs, in time, money and effort. While the perspectives of parents and teachers enhanced the understanding of their overall conceptualisation of ADHD, a larger sample from multiple locations could provide a greater breadth of information, making the findings more generalisable. As different results might be obtained in different locations, the sample in this study did not adequately reflect the population of Scottish and Romanian mothers, teachers and support staff. Future studies could aim to include as many participants as possible, located in different regions across the countries. More sophisticated regression analysis could be carried out in future research with data collected from larger populations in different settings.

3.4. Research instruments

3.4.1. Self-reported questionnaire

The instrument was developed based on pilot data obtained for 34 Romanian primary school class teachers. The research undertaken as a part of my MRes in Educational Research degree involved the administration of 3 instruments designed to investigate the relationship between teachers' characteristics, teachers' knowledge about ADHD and teachers' attitudes towards ADHD in the primary school.

Initially, a demographic questionnaire consisting of 4 sections was constructed. In the first section, teachers provided general information about their age, gender or the subject they were teaching. The second section focused on teachers' formalised learning, including information about their highest level of education and the current certification or number of degrees that they held. Information about teachers' general experience or specific experience in teaching children diagnosed with ADHD was collected in the third section of the form. The last section gathered information about teachers' professional development. This part was represented by the number of past seminars, conferences or workshops undertaken in the field of ADHD.

Teachers were also asked to complete the Knowledge of Attention Deficit Disorders Scale (KADDS), an instrument used to measure teachers' knowledge about ADHD. The questionnaire was originally developed by Sciutto and Feldhamer (2000), being one of the most widely used scales for testing knowledge about the disorder. The questionnaire was obtained directly from Professor Sciutto from Muhlenberg College in the United States,

who granted permission for the instrument to be used in this particular study. The original KADDS items are presented in Appendix A.

Using a true, false or don't know format, KADDS was designed to measure knowledge and misconceptions of ADHD in 3 specific areas:

- Symptoms/diagnosis of ADHD (9 items), e.g. "ADHD children are frequently distracted by extraneous stimuli";
- The treatment of ADHD (12 items), e.g. "Electroconvulsive Therapy has been found to be an effective treatment for severe cases of ADHD";
- General information about the nature, causes and prognosis of ADHD (15 items), e.g. "Reducing dietary intake of sugar is generally effective in reducing the symptoms of ADHD";

This format allowed for differentiation of what teachers do not know from what they believe incorrectly (e.g. misconceptions). The 36 items questionnaire was piloted by its authors on 63 American elementary school teachers, yielding a good internal consistency with a Cronbach's Alpha of 0.81 (Sciutto, Terjesen & Bender-Frank, 2000). Moreover, the 3 subscales within the measure had moderate levels of internal consistency, ranging from 0.52 to 0.75. Further, to test the stability of the scale, the authors administered the instrument to a sample of 185 college students two weeks apart. Test-retest correlation scores were moderate to high, ranging from 0.59 to 0.76.

On the other hand, considering KADDS as a valid measure of ADHD knowledge implied that participants' prior exposure to the disorder had to be correlated with scores on the KADDS. Indeed, results from various studies supported a significant difference in the performance of individuals who had previous exposure to ADHD when compared with the performance of those who had no experience of the disorder (Sciutto, Nolfi, & Bluhm, 2004). Similarly, individuals with more training and experience related to ADHD should also receive higher scores on the measure. Indeed, Herbert (cited in Sciutto, Nolfi & Bluhm, 2004) found that teachers who had the least amount of training regarding children with ADHD received lower scores on the KADDS than either school psychologists or school counselors. Another method of assessing the validity was to examine whether scores on the scale changed as the result of educational interventions. Bender (cited in Sciutto, Nolfi, & Bluhm, 2004) concluded that elementary education students showed improvement in their scores after an educational intervention program focused on the disorder.

The third instrument used for my Masters Project was a self-rated attitude questionnaire. After consulting the relevant literature, the questionnaire was constructed with the aim of measuring teachers' attitudes towards children diagnosed with ADHD. Figure 1 explains the idea behind the development of the instrument, showing that the attitude is a complex concept made up of multiple dimensions that in their aggregate define the construct itself. The instrument focused on measuring global and domain specific (e.g. cognitive, affective and behavioural) attitude. The following figure shows how the tripartite model of attitude was adapted for this study.

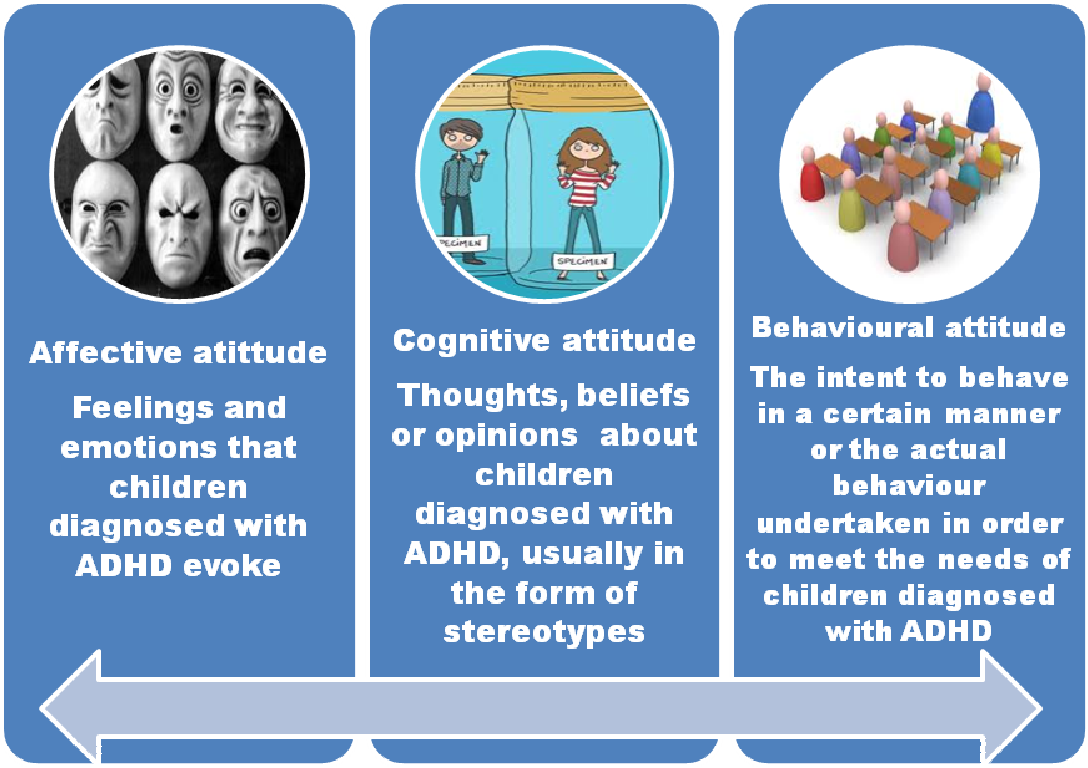

Figure 1. The adaptation of the 3-components model of attitude.

Many of the items were produced from the existing literature and previous measurements in the field. For a precise statistical analysis, the questions were close-ended, using a 5 point Likert scale. The Likert scales were usually employed with a number of different response formats, among the most popular being the frequency, degree or extent similarity and agreement (e.g. Page-Bucci, 2003). However, as teachers could have varying interpretations of the numerical value accorded to frequency category labels and often the distance between categories was unequal (Cummins & Gullone, 2000), the vague interval labels were eliminated from the present questionnaire. The instrument simply required teachers to indicate their degree of agreement or disagreement with statements about

children diagnosed ADHD by placing themselves on a scale where 5 represented Agree and 1 represented Disagree.

Further, the uni-dimensionality was assured by the fact that the instrument enabled the ranking of teachers along a single continuum ranging from those who had positive to those who had negative attitudes. The adequacy of each item was determined primarily by its relationship to a total score obtained. All items were related only in the context of the dimensions under consideration. The items were judged and analysed as being neutral from the point of view of the subject's culture.

The 62 items version of the questionnaire was pre-piloted with 5 Master students in Educational Research. The most commonly reported errors included the issue of two items measuring the same aspect or two aspects simultaneously, items being included in a wrong subscale or items being too difficult to understand. As a result, some items were removed, rephrased or moved into other subscales. The pre-pilot questionnaire had 55 items, efforts being made to obtain an approximate equal number of items within each scale. Due to the time constraints, pilot data was collected by e-mail from 7 Romanian primary-school teachers who were identified from a National Educational Forum. The internal consistency of the instrument was statistically tested employing the Cronbach's Alpha value. The aim was to examine if the items were well constructed in order to have a reliable measure of the concept. It was most commonly reported that a questionnaire scale has internal consistency if the Cronbach's Alpha value is above 0.70. Cronbach's Alpha coefficients were thus calculated for the 3 subscales of the questionnaire. Because initial values were low, 16 items were removed from the instrument. After repeating the reliability analysis, all the subscales had acceptable values of the coefficient (e.g. affective attitude=0.71, cognitive

attitude=0.70, behavioural attitude =0.71). Moreover, the Cronbach's Alpha value for the total questionnaire was 0.83. In other words, at least 83 % of the variance in the empirical test would be held in common with a perfect measure of the same construct. The questionnaire used acquiescence responses, an approximately equal number of positive and negative items (e.g. 19 items and 15 items). Moreover, these positive and negative items were presented alternately in order to reduce the effect of respondent set. Importantly, negative items were reversed scored in the pilot administration and in the final version of the questionnaire. The initial questionnaire is presented in Appendix B. It consisted of 34 items and presented the following distribution of the items (see Table 2).

QUESTIONNAIRE SCALE	ITEMS	ITEMS NO
Affective Attitude	**1, 5, 11, 12, 17, 20, 24, 29, 33**	**9 ITEMS;**
Cognitive Attitude	**2, 7, 8, 9, 10, 14, 19, 22, 23, 25, 26, 28, 30, 32, 34**	**15 ITEMS;**
Behavioural Attitude	**3, 4, 6, 13, 15, 16, 18, 21, 27, 31**	**10 ITEMS;**
TYPE	**ITEM**	**TOTAL NUMBER OF ITEMS**
Positive Items	**1, 2, 3, 5, 9, 11, 13, 15, 16, 18, 19, 20, 21, 23, 25, 28, 31, 32, 33,**	**19 ITEMS;**
Negative Items	**4, 6, 7, 8, 10, 12, 14, 17, 22, 24, 26, 27, 29, 30, 34**	**15 ITEMS;**

Table 2. Items distribution within the initial self-reported attitude questionnaire.

3.4.2. The final version of the instrument: Item Analysis Report

After the administration, the items' level of difficulty, the discriminatory capacity and the internal consistency were carefully analysed for all 3 instruments presented above. The aim was to have a single instrument with as much validity and reliability as possible. The first step of the items analysis was to identify prior studies which used the scale and start making some comments about the instrument validity and reliability (e.g. Akram et al, 2010). Each individual statement of KADDS was analysed, highlighting mainly the appropriateness of the items for the specific design. Double items or items constructed in a very vague and ambiguous manner were removed from the instrument or rephrased.

To determine the difficulty level of test items, a measure called the Difficulty Index was used. Psychometric analysis of the preliminary questionnaire showed that all items had a satisfactory index of difficulty. The questionnaire average index of difficulty was between 0.3 and 0.8. The item discrimination index was employed in order to measure how well an item was able to distinguish between teachers who were knowledgeable and those who were not. Showing very weak discrimination between high ability and low ability participants, 4 items were removed from the scale (e.g. item 8, 10, 27, 35). Internal consistency was statistically tested employing the Cronbach's Alpha value. The aim was to examine if the items were well constructed in order to have a reliable measure of the concept. Firstly, Cronbach's Alpha coefficients were calculated for the 3 sub-scales of the questionnaire and for the whole instrument. Because initial values were low, some items were removed and the reliability analysis repeated on the remaining items. After reliability analysis, 18 items were removed, including those with weak discrimination indexes.

The 3 subscales within the measure had moderate levels of internal consistency, ranging from 0.61 to 0.76. The Cronbach's Alpha value for the final questionnaire was 0.70. In other words, at least 70 % of the variance in our empirical test would be held in common with a perfect measure of the same construct. However, after the administration, the structure of the items was improved so that a better Alpha Cronbach's value is expected in future research. To know how correlated each of the subscales were to each other and to the overall scale, the Pearson Product-Moment Coefficient of Correlation was computed. Correlations between subscales ranged from 0.36 to 0.57, suggesting that they represented fairly discrete aspects of teachers' knowledge. There was sufficient intercorrelation between the subscales to suggest that they were aspects of a more global evaluation.

The 16 items selected from KADDS represented the first section of the final instrument (e.g. General knowledge about ADHD-5 items, Knowledge about treatment-5 items, Knowledge about symptoms/diagnosis-6 items). Furthermore, each item was individually adapted to measure parents' knowledge about ADHD. However, it is worth mentioning that the initial version of KADDS was tested and applied initially to a cohort of American teachers. Due to the small scale nature of this project, the questionnaire was not piloted with parents prior to its administration.

Furthermore, in line with the original development of the instrument, knowledge about ADHD was measured with true, false and don't know statements. As Jones (2006) also ascertained, error choice method might be considered too limited to get a clear picture of teachers' and parents' knowledge, being unable to generate enough variability in the scores. These items might not be ideal for a knowledge questionnaire, because parents and teachers who did not know the answer had a 50 % chance of merely guessing the correct

answer. The scoring may have been too easy for the participants or might have determined some of them to choose the most convenient option, namely the *don't know* alternative. Additionally, future research could aim to improve the psychometric properties of this knowledge measure. According to Oim (2004), including a sample of psychologists as a control group could be one part of future research in this field.

For the self-rated attitude questionnaire, the item analysis identified some items measuring the same aspect or two aspects simultaneously, items being included in a wrong subscale or items being too difficult to understand. Unclear, confusing and problematic items were reworded, moved into a different subscale or taken out from the instrument. Cronbach's Alpha value for the subscales ranged for 0.85 (e.g. affective attitude) to 0.95 (e.g. cognitive attitude) with the exclusion of 8 inconsistent items. The Cronbach's Alpha value for the final questionnaire was 0.94, meaning that the instrument had very good internal consistency.

The purpose of the next analysis was to obtain a sense of how much overlap was obtained in the measurement of subscale constructs. The correlation matrix revealed that correlations between the subscales generally ranged from 0.36 to 0.49 which demonstrated that, rather than collapsing the affective, cognitive and behavioural attitudes into one category, the results could be interpreted separately for each subscale. The 15 items selected from the self-rated attitude questionnaire (SRAQ) represented the second section of the final instrument (e.g. affective attitude-5 items, cognitive attitude-5 items and behavioural attitude-5 items). This section of the questionnaire used a 5 point Likert scale which took the form of Strongly Agree/Strongly Disagree. The vague intermediary labels were eliminated to avoid participants' confusion. Although the aim of this study was to

create a highly reliable scale, the Likert scale suffered from serious limitations. For instance, the presence of the mid-point on the scale might produce a distortion in the results obtained. Parents and teachers could avoid extreme response categories. They might agree with statements as presented in order to impress or put themselves in a more socially favourable light. Future research could try resorting to a scale without a mid-point that seems to help alleviate this social desirability bias without changing the direction of opinion.

Conclusively, the item analysis permitted the re-elaboration of the instrument, the new version consisting of 31 items (e.g.16 items-knowledge about ADHD, 15 items-attitudes towards ADHD). The final version of the questionnaire is presented in Appendix C. Each item was also adapted to measure parents' knowledge and attitudes towards ADHD (See Appendix D). The survey underwent 2 translations into Romanian and forward-back translation into English by two bilingual psychologists. The aim was to obtain culturally appropriate content across language. The analysis of conceptual equivalence was performed by 5 experts in emotional and behavioural disorders, which provided data for the determination of the content validity of the instrument. The analysis of the subscales of the instrument showed a good level of agreement between the experts. The items were subsequently revised and considered to be adequate for the administration of the instrument.

This instrument is a completely new aspect introduced by this study, and as such its contribution requires further testing and validation. However, I am aware that the way in which the concepts of knowledge and attitudes were conceptualised could affect the final results and their interpretation. For instance, knowledge was defined as the possession of

appropriate information about the nature, causes, symptoms, diagnosis and treatment of ADHD. Eagly and Chaiken's (1993) definition of attitudes was employed where attitudes represented a psychological tendency that was expressed by evaluating a particular entity with some degree of favour or disfavour. Attitudes were defined by the same authors as a combination of 3 conceptually distinguishable affective, cognitive and behavioural reactions to a certain object. Future studies might chose to employ a different understanding of these concepts and therefore produce different results.

3.4.3. Semi-structured interviews with parents, teachers and support staff

Given the goals and purpose of this research, semi-structured interviews were chosen as the complementary method of data collection. No attempts were made to design a study from which the results could be generalised to a larger population. The interviews had the potential to provide a detailed and personal insight into subjects' life worlds and the world of their daily life (Kvale, 1996).

The following figure is adapted from Chirban (1996, p. 14-16) and describes the stages undertaken in order to conduct the semi-structured interviews.

1) INITIAL CONTACT

Explains goals

Clarifies expectation

Set the stage for the interviewing process

2) THE FIRST ENCOUNTER

Developing rapport

Creating opportunities for engagement

Engagement begins

Surfacing of issues, feelings and ideas

3) THE ENGAGEMENT

Receiving and reciprocating opportunities

Deepening of interview

Resonation increases

Engagement grows

4) THE NEW SPACE, NEW RELATIONSHIP

Both participants begin a new experience

Actively growing in risk taking, self-awareness

authenticity, attunement and reciprocity

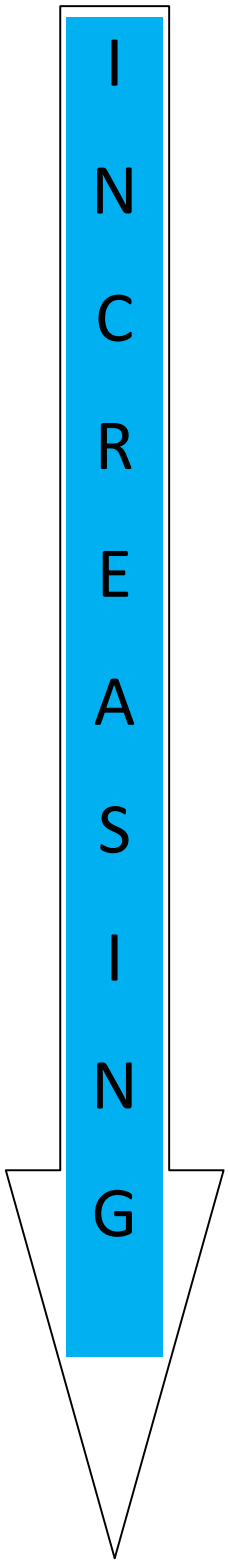

Figure 2. Stages of a Semi-Structured Interview.

The interviews, which took approximately one hour to complete, were designed with two purposes in mind. Firstly, the interview gave the subjects the chance to openly express their individual opinions, feelings and beliefs. The interview questions were used as an aide memoire, and the format of the interview was modified to accommodate the conversation style of each participant. Parents, teachers and support staff were allowed to digress as much as they needed and unanticipated issues raised by participants as being of importance to them were pursued.

Secondly, it was also necessary to elicit information on the same set of topics and sub-topics across all participants. On the basis of key issues identified from the literature, an interview schedule was constructed with the aim of exploring in greater depth the knowledge and attitudes that teachers and parents had towards children diagnosed with ADHD. Pre-established themes, codes, and patterns were designed taking into consideration the questionnaire administered in the first phase of the research. The topics covered firstly the area of knowledge about ADHD, including questions about the diagnosis process, associated features, symptoms and treatment of ADHD. The interviews also focused on the area of attitudes towards ADHD. The cognitive attitudes were explored by asking questions about the thoughts, beliefs and ideas about children diagnosed with ADHD and the affective were represented by the feelings and emotion evoked by children diagnosed with ADHD. Questions about the strategies and interventions undertaken in order to meet the needs of children diagnosed with ADHD and the level of existent co-operation and collaboration) were related to the bevahioural component of attitude.

The semi-structured interviews were characterised by a combination between flexibility and structure. The open-ended questions incorporated in the interview schedule were developed on the basis of a review of literature, which has brought to light several factors that appear to shape parents' and teachers' knowledge and attitudes towards ADHD. See Appendix E and F for the interview schedules for parents, teachers and support staff.

3.5. Research Phases

The research used a concurrent nested approach to the mixed-method design in order to gain insight and to examine more in depth the conceptualisation of ADHD within two cultural settings. In phase 1 ("identifying patterns"), Romanian and Scottish teachers' and parents' knowledge and attitudes towards ADHD were investigated using an instrument specially designed, piloted and validated for the purpose of the research. The scores obtained by the participants were statistically analysed with the aim of testing if the variations, effects or correlations were significant, providing insights about various knowledge and attitudinal patterns that existed within the two countries. The analysis undertaken in phase one guided the further execution of the small, more in depth interpretations. The next major step involved the intensive qualitative analysis of one or more cases that were best explained by the model developed in the first phase. Together with those representative cases, the study explored in more detail the statistically nonsignificant results, key significant predictors and variables that distinguished between groups, outliers or extreme cases.

In phase 1, in order to recruit Scottish parents and children diagnosed with ADHD, formal permission to conduct the research was obtained from the National Health Service and the Research and Development offices. The ethical review consisted of completing two on-line application forms through the Integrated Research Application System (IRAS), identifying and establishing contacts with a consultant paediatrician who acted as a local collaborator, site specific assessment, explaining and answering questions about the project in a meeting with 15 members of NHS and further revisions and clarification. On the other hand, in Romania, there were no formal requirements in order to undertake research within hospitals, clinics or health centres. Permission was granted to recruit a number of parents of children diagnosed with ADHD after the empirical part of the research was clarified to the specific institutional board.

After both approvals were obtained, patient files were used to identify those children who met study criteria in the clinic population from Scotland and Romania. The selected participants were invited to the outpatient clinic. With the help of the direct care team, I personally introduced myself and provided information about the aim of my study, highlighting that I was extremely interested to learn more about what they know about ADHD and to better understand their experiences and attitudes in relation to this condition. 50 parents were recruited from each country between January 2011 and September 2011, capturing the breadth of perspectives from a range of families seeking care for what was ultimately diagnosed as ADHD. The study is registered with the UK Clinical Research Network Study Portfolio (Id number 11577), a database of high-quality clinical research studies.

After receiving the completed parental informed consent form, I attended each patient's regular appointment at the clinic, where basic questions were asked about the treatment and the child's academic and social functioning. When the appointment finished, parents where invited into another office allocated by the staff members, an aspect which proved to be both convenient and well-suited for the task at hand. With each parent, I went through the questionnaire's items and offered more explanations when a question was not clear. However, I tried to maintain a non-directive approach and offered probing and guidance rather than influencing their responses. There were situations when mothers started speaking for 30-45 minutes without a pause, trying to expand their responses to certain areas of concern. Since every questionnaire transformed into a semi-structured interview, I considered it would be very important at that point to ask permission to record this additional conversation. All participants agreed to be recorded and they were very positive about taking part in a subsequent interview.

The procedures used to collect the data from teachers and support staff were generally similar for the Scottish and Romanian sample. Two educational services were contacted to request permission to collect data from its mainstream primary schools. Application forms were completed including information about the outline of the project and the main research questions, the research timetable, what teachers would be asked to do, the procedures required, the time spent by each individual and details about the possible benefits or risks for the participants. After acquiring the written approvals, recruitment started with attaining authorisation from the school headteachers. All the primary schools based in the selected Romanian (e.g. 49) and Scottish districts (e.g. 41) were contacted from the online list identified from the website of each council. Headteachers were

approached via email, follow-up phone call and personal visit to ask permission for the teachers to be involved in the study. I also attended several school meetings where I provided a short explanatory lecture about the background, goal and outcomes of the study. Moreover, a flyer summarising the main aspects of the research was posted to each school (See Appendix G).

The headteachers were given one week to consult with their staff and decide if they would be willing to take part in the study. However, obtaining consent from the schools often presented challenges. The challenges were sometimes a result of headteachers' very busy schedules or simply forgetting about the initial research request. To ensure maximum participation rates, a reminder call was made to some of the schools. The interested headteachers were then visited at their school, where, for each teacher and support staff, they received a packet including an information sheet about the research, 3 consent forms to be signed (e.g. one for the participant, one for the researcher and one to be kept in the school records) and the self-report questionnaire. It was initially stated that a two-week period would be given for the completion of the questionnaires. After the period ended, I went to the participating schools to pick up the completed surveys and to give a thank you letter to those who completed the survey and to remind those who had not. However, some headteachers had to be phoned and e-mailed several times to remind them that the questionnaire needed to be completed and a date was set for collection. Due to teachers forgetting about the questionnaire or not having had time to complete it, an extension period was granted for some schools. Additionally, extra questionnaires were left for respondents to fill out if they lost their originals. At an agreed later date, I returned to the participating schools to collect the remaining completed surveys as well as leave another

thank you letter. From the day it was distributed until the final surveys were collected, the surveying process took approximately 2 months for the Romanian sample and 3 months for the Scottish sample. However, in comparison with the parents' sample, I did not have the opportunity to administer the questionnaires personally, in a face to face manner. Maybe more in depth information could be obtained if the time frame would allow the development of a closer relationship with teachers and support staff.

Based on the patterns identified in phase 1, the study focused in phase 2 ("gaining insight and understanding meanings") on a small number of selected participants. The study concentrated not only on the sample of teachers and parents who obtained average scores on the self-report questionnaire but also on some extreme cases with either very low or high score patterns. Participants with different response patterns were selected and agreed to take part in the next stage of the project. Semi-structured interviews were subsequently used as the best means of uncovering and understanding teachers', support staff's and parents' knowledge and attitudes towards ADHD.

5 Scottish mothers and 5 Romanian mothers were interviewed in their own homes. 3 interviews with teachers and 3 interviews with support staff were conducted on the grounds of the selected mainstream schools from Scotland and Romania. In these circumstances, it was possible that the answers obtained were influenced by the setting in which the research was conducted. For example, parents attended the interview in the privacy of their homes whereas teachers engaged in the conversation during the school breaks. Environmental constraints also made attending to the study tasks difficult for some participants. For instance, some parents answered the interview questions with their children present and teachers were frequently interrupted by students or fellow colleagues.

Many of them appeared distracted or rushed through the interview. In a more relaxed environment their answers might have been different. Furthermore, as Benson (2000) argued, the possible presence of a Hawthorne effect might produce socially desirable responses, especially when participants were asked about their knowledge and attitudes towards a controversial topic like ADHD.

The two research phases are clearly explained in Figure 3.

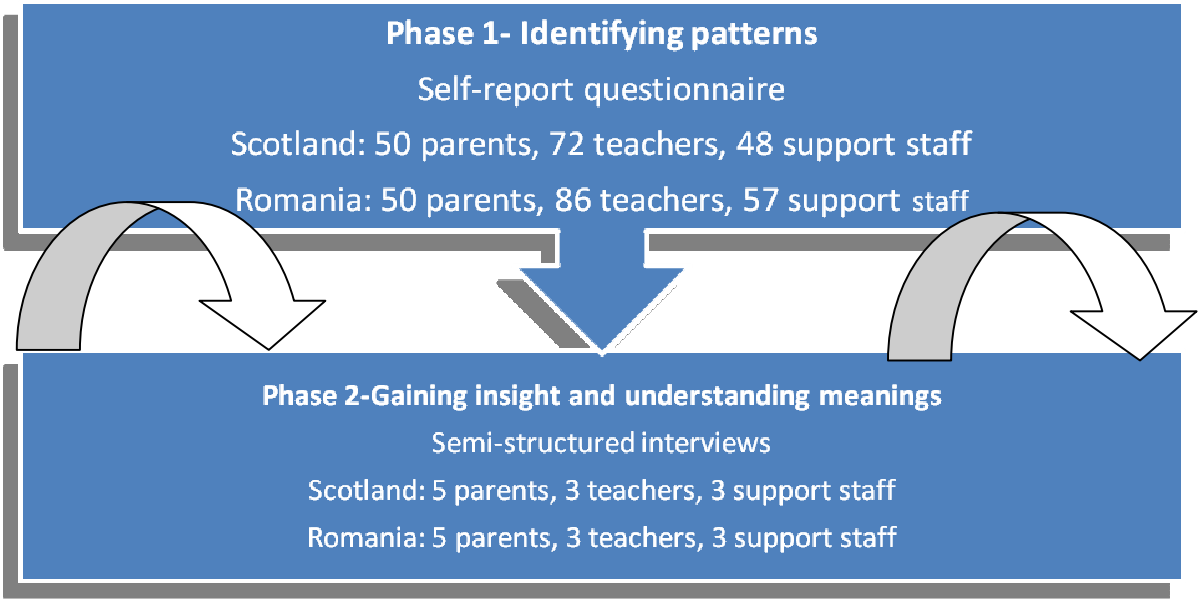

Figure 3. Research phases.

3.6. Reliability, validity and authenticity

According to Miles and Gilbert (2005), reliability refers to the question of whether the results are repeatable if the investigation is conducted again. In the questionnaires used in this study, items' level of difficulty, the stability and the internal consistency were carefully analysed. To note, the Alpha Cronbach's value for the final questionnaire was moderate and the related results should be treated with caution. However, after the administration, the structure of the items was improved so that a better internal consistency is expected in future research. It was beneficial to compare the properties of the questionnaire with other instruments with established valid and reliable psychometric characteristics. Unfortunately, as the measurement itself was a self-constructed instrument, it was very difficult to identify any prior testing for comparison.

According to Roberts and Ilardi (2005), research is said to be valid to the extent that it actually reflects the constructs that it is aimed to measure. In relation to the internal validity, the instruments applied were aiming to reveal teachers' and parents' understanding of the items addressed. Furthermore, consideration was given to a number of moderating variables which might have influenced the final results (e.g. ethnicity, socio-economic status, subtypes of ADHD or the presence of other comorbid disorders). In relation to external validity, participants were aware that they were being investigated and therefore the findings cannot be applied to other category of teachers, support staff and parents in their everyday life.

Due to acces problems, ethical requirements and approval procedures, the research was conducted on a purposeful sample and not all participants were randomly selected. Participants were not entirely representative of the Romanian and Scottish population, making it difficult to generalise the findings to a broader sample. The inferences drawn from this study might thus be suspect since lower sample sizes yielded greater margins of sampling error. Researchers undertaking longer longitudinal studies are encouraged to plan ahead so that random selection is possible and achievable.

Validity and reliability in the qualitative phase of this research could be better defined as whether the data is plausible, credible and trustworthy, being able to be defended when challenged. Rather than aiming to achieve representativness, this part of the study strived to generate data in a way that conveys authenticity and trustworthiness. In this regard, intercoder agreement was taken into consideration, refering to the extent to which two or more independent coders agree on the coding of the content of interest with an application of the same coding scheme. The intercoder agreement reported in this study was based on the comments made by two coders and on all completed interview transcript pages. Intercoder agreement for each of the thematic categories was calculated, as well as an overall average agreement across all themes. Intercoder agreement ranged from 0.68 to 1.00, with an average of 0.90.

Interviewing within this research emphasized the experiential and was intended to explore parents', teachers' and support staff' understandings of ADHD as lived and told in their stories. In particular, each participant who was approached was given the opportunity to refuse to take part in the project so as to ensure that the data collection sessions involved only those who were genuinely willing to participante and prepared to offer data freely.

Participants were encouraged to be frank from the outset of each interview session, being made aware that there were no right answers. Parents, teachers and support staff, therefore, contributed with ideas and talked of their experiences without fear of losing credibility.

Furthermore, the questions participants were asked were supplemented by probes to explore and gain a deeper understanding of ADHD. This approach was enhanced by encouraging teachers and parents to constantly explore and revisit their insights into ADHD. The fresh perspective that such individuals were able to bring allowed them to challenge my assumptions taking into consideration that my closeness to the project could have inhibited my ability to view certain aspects with real detachment. However, although participants expressed their own ideas and thoughts without any kind of interruption or redirection, I have maintained a level of awareness of how my own values, beliefs and expectations may have affected what I have chosed to investigate, what I saw, and how I have interpreted what I saw. Like most research, my study was not completely value-free. According to Johnson and Onwuegbuzie (2004), conducting a fully objective and value-free research is a myth, even though the regulatory ideal of objectivity could be useful. My research involved looking through the eyes of the participants. For this reason, I become greatly involved in the lives of teachers and parents who took part in my study and formed friendships with some of them. As with any research, reliability, validity and authenticity stem from the appropriateness, thoroughness and effectiveness with which those methods were applied and to the care attributed to thoughtful weighing up of the evidence (Bazeley, 2006). Although during the whole research process, data was collected, analysed and reported carefully, I have maintained a high level of awareness about the limitations of administering questionnaires and interviews, as they could be modified in a mixed methods

environment. However, the data triangulation employed in this study reduced the subjectivity of my investigation, making it less biased and more authentic. The use of different methods in concert compensated for their individual limitations and exploited their respective benefits.

3.7. Ethical considerations

The ethical considerations related to this study included acquiring approval from the following institutions and committees:

- ✓ Scotland: University of Stirling, National Health Service (NHS), R&D Resource Centre, Council Education Service;
- ✓ Romania: CAMHS, The School Inspectorate;

See Appendix H and Appendix I for the approval letters required for this study.

The study followed the Stirling Code of Good Research Practice, the British Educational Research Association Code of Ethics for Educational Research, the Economic and Social Research Council Framework for Research Ethics and the NHS National Research Ethics Service Guidelines. Data collection, analysis and storage abided by the Data Protection Act (1998).

Informed consent, privacy and confidentiality of participants were taken into account. Participants were given an information sheet and consent form to be signed prior to the research in compliance with the Data Protection Act and with the ethical requirements. Parents, teachers and support staff were given a packet consisting of the

research information sheet, 3 consent forms to be signed (e.g. one for the participant, one for the researcher and one to be kept in the medical records/schools) and the self-report questionnaire. The information sheet included details of the research (e.g. funding source, sponsoring institution, name of project, contact details for researchers and how to file a complaint, the nature and scope of the study, what was involved in participating, benefits and risks, terms for withdrawal, what would happen to the data collected (e.g. during research, dissemination and storage, archiving, sharing and reuse of data), what the strategies were for assuring ethical use of the data (e.g. procedures for maintaining confidentiality, anonymising data where necessary, especially in relation to data archiving) and the intended beneficial outcomes which might result from their participation in the study. The written consent documentation also included a short and concise signature form.

As for the teachers, the main aims and objectives of the study were explained during the staff meetings organised within the school. However, due to access difficulties, for the vast majority, I had to rely on the headteacher to provide teachers with the details about what was involved in my project. Each teacher and support staff subsequently received a research packet containing a detailed information form, which guided teachers in making an informed decision in relation to their participation in this study. The information sheets for parents, teachers and support staff are attached in Appendix J and Appendix K. The required letter to the GP is also presented in Appendix L.

The voluntary nature of the study was also emphasised in the consent document. Participation in this study was entirely voluntary, with parents, teachers and support staff being able to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting their future medical care, the relationship with

the medical staff or their teachers' status. The information about confidentiality and anonymity was presented in the information sheet and confirmed verbally anytime that it was required. Taking into consideration the purpose of this research, participants were asked to write down their names on the questionnaire. I assured the participants that questionnaires were confidential but not anonymous as their responses allowed the development of a purposive sample for the next phases of the study where a limited number of teachers and parents were further investigated. These direct identifiers were used only for the follow up phase of the study but they were coded and removed after the data collection was finalised. No name or any other information that would in any way personally reveal their identity was mentioned in any hard copy or electronic version of the final thesis. More specifically, in the data analysis, individuals, groups or organisations were anonymised so that they could not be identified. The subsequent transcribed interviews, textual or audio data included just pseudonyms, replacement terms or other more vague descriptors. An anonymisation log of all replacements, aggregations or removals was created and stored separately from the actual data files. No person other than the participants themselves could disclose information to any other person without their authorisation. The project contained reasonable safeguards to protect against identifying directly or indirectly any teacher or parent in any report of the research project. As discussed before, the research included procedures to remove or destroy at the earliest opportunity information that would enable identification of the participants.

Consistent with the spirit of full disclosure of methods and analyses, the data will become available after completion of the project and the findings publicly disseminated. Interested participants will receive a summary of the final thesis with the most important

findings. Furthermore, research findings, papers and publications will be made available in Scotland and Romania, being also translated into Romanian. However, no documents will be published that are likely to identify an individual unless specifically agreed with them. Research data is a valuable resource with a significant value beyond the original research. For this particular study, sharing data could encourage scientific inquiry and provide important resources for education and training. Under certain circumstances, the research datasets, findings and outputs could be used for teaching purposes. The consent form notified participants that data might inform guidance, teaching materials, training events and workshops. Teachers and parents were advised in the information sheet that the use of real as opposed to synthetic data will add interest and relevance to any course, bring both substantive and methodological topics alive and will ensure that the level of knowledge acquired is pertinent to current issues. Students could have the opportunity to understand the rationale for collecting data and to develop critical faculties to judge the strengths and weaknesses of a particular approach. Parents, teachers and support staff were also informed about the possibility that teaching activities might be undertaken in the languages in which the study was conducted.

No major potential risks and burdens were associated with this study. However, as mentioned before, the research was undertaken in a period when the phenomenon of ADHD raised public concern and provoked continuous debate. The research emphasised the importance of differences in perceptions and mentalities when working with participants from diverse cultural backgrounds, recognising and respecting the cultural and religious values of participants.

3.8. Data Analysis

3.8.1. Analysing the quantitative data

IBM Statistical Package for the Social Sciences (SPSS) Statistics Version 19 was employed to analyse the quantitative data. The information gathered in the survey was processed into two different SPSS files (e.g. one for the parents and one for the teachers and support staff). In terms of coding the variables, having knowledge about ADHD implied the possession of appropriate information about the nature, causes, symptoms, diagnosis and treatment of ADHD. Initially, responses were entered into the SPSS as follows: True=1, False=2, Don't Know=3. A misconception was defined as an incorrect response (e.g. answering FALSE to a question for which TRUE is the correct answer). Don't Know responses were not considered misconceptions. Tabulation of misconceptions was conducted before recoding as correct/incorrect. In order to obtain the scores for each subscale and the total scores, variables were assigned new values according to each answer obtained so that the correct answers got a score of 1 and incorrect and Don't know answers got a score of 0.

- ✓ Correct answer is false: (1 = 0) (2=1) (3=0) e.g. items: 2, 3, 4, 7, 10;
- ✓ Correct answer is true: (1=1) (2=0) (3=0) e.g. items: 1, 5, 6, 8, 9, 11, 12, 13, 14, 15, 16;

Attitudes were defined by Eagly and Chaiken (1993) as representing a combination of 3 conceptually distinguishable affective, cognitive and behavioural reactions to a certain object. Initially, responses were entered into SPSS according to the number selected by participants on the 5 point Likert Scale. The assigned values were then recoded as follows:

- ✓ Positive attitude: 1=1, 2=2, 3=3, 4=4, 5=5 e.g. items: 17, 18,19a, 19b, 19c, 19d, 20, 22, 23, 26, 29, 31;
- ✓ Negative attitude: 1=5, 2=4, 3=3, 4=2, 5=1 e.g. Items: 21, 24, 25, 27, 28, 30;

Subsequently, the data analysis was divided in two sections, according to each set of research questions. For research questions 1 and 2, the total scores and various patterns of responses of teachers and parents for each of the KADDS and SRAQ items were calculated using Descriptive statistics. Teachers' and parents' mean scores and standard deviations were obtained for the whole instruments as well as for its subscales. Analysis of Variance or Paired Sample T-Test was employed to compare the mean scores among the subscales and between the subscale and the total KADDS and SRAQ scale. For research question 3, since teachers and support staff constituted a small convenience sample, the inferential statistics were undertaken only for exploratory reasons with no statistical significance. Conclusions were drawn only about the difference between the two patterns of teachers' and support staffs' knowledge and attitudes identified within Romania and Scotland. Parents were randomly selected from the clinical population and inferential T Tests were computed to compare the results obtained by Romanian and Scottish parents on KADDS and SRAQ.

3.8.2. Analysing the qualitative data

The interviews were analysed through thematic analysis, where coding categories were generated from the group material. The analysis focused on the interview transcripts (verbal aspects) and the non-verbal aspects of the conversations (tone of voice, posture, gesture, pause, interruptions) which were recorded in notes taken at the time. Participants' narratives were explored in relation to the literature and in relation to the theoretical framework previously described in this chapter. Verbatim quotes of participants using pseudonyms in the place of names were included in the interpretation of the results. As Table 3 shows, these coding categories focused on the identifiable words, phrases and patterns present in the transcriptions (Richie & Lewis, 2003, p. 212).

DATA MANAGEMENT	DESCRIPTIVE ACCOUNTS	EXPLANATORY ACCOUNTS
Identifying initial terms or concepts	**Sorting data by themes and concepts**	**Establishing typologies**
Labelling or tagging data by concepts or themes	**Summarising and synthesising data**	**Detecting patterns, associative analysis and identification of clustering**
Generating themes and Concepts	**Assigning meanings and assigning data to themes/concepts to portray meanings**	**Refining and distilling more abstract concepts**
	Identifying elements and dimensions, refining categories, classifying data	**Developing explanations and seeking applications to wider theory**

Table 3. A conceptual framework to analyse interview data.

The detailed analysis was performed according to each category by offering some general conclusions and relevant remarks. This approach was selected because it is favoured for understanding the different ways in which people describe or discuss a particular topic or phenomenon. The comprehensive purpose of this type of data analysis was to find patterns within a framework or create a deeper understanding of a topic area. The aim was to bring all the ideas on the same topic together in one place, which aligned well with the goals of this study. However, some themes could be clustered together, whilst others were found to be either subordinate or deviant from the original focus of the study. This method of analysis resulted in a set of themes unique to my research problem, themes which are included in the interview schedule for further exploration.

4. Results of the self-reported questionnaire

4.1. Research sample description

4.1.1. Teachers and support staff sample description

The Romanian sample consisted of 57 support staff and 86 mainstream primary school teachers. All participants were females. Figure 4 shows how the age intervals were relatively equally distributed between under 25 and 54 years old, with only 5 participants over 55 years old.

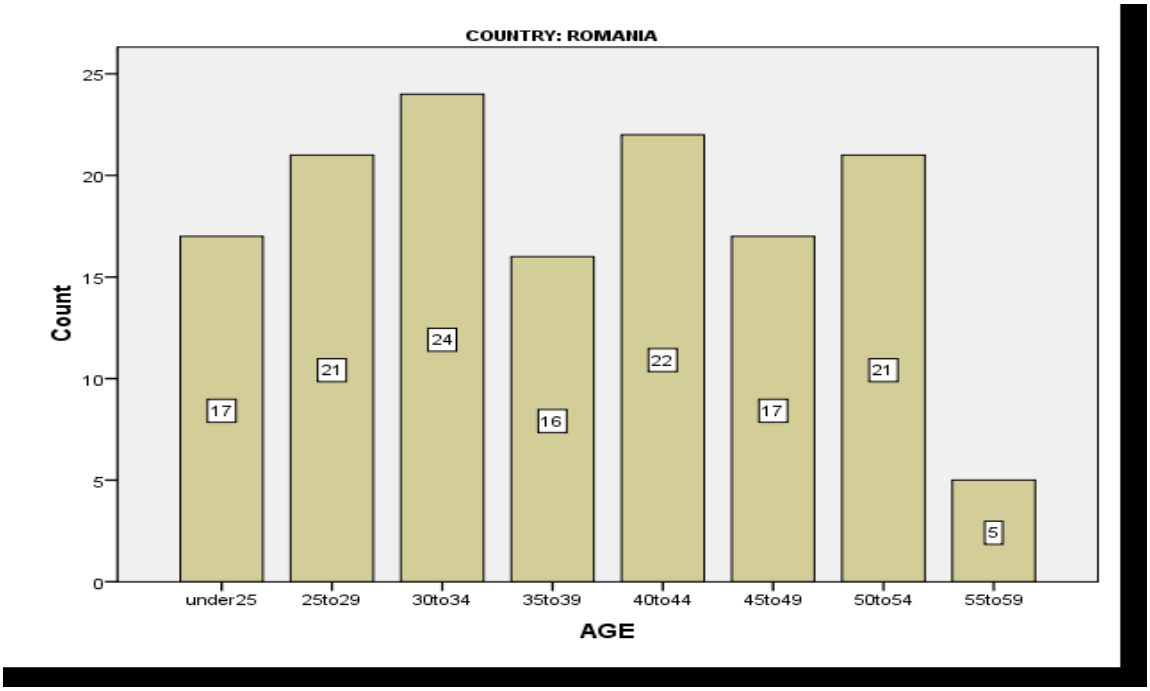

Figure 4. Age distribution within the Romanian sample of teachers and support staff.

The Scottish research sample consisted of 48 support staff and 72 mainstream primary school teachers. All participants were females. In comparison with the Romanian sample, Scottish teachers and support staff were younger, with 21 participants between 25 and 29 years old (See Figure 5).

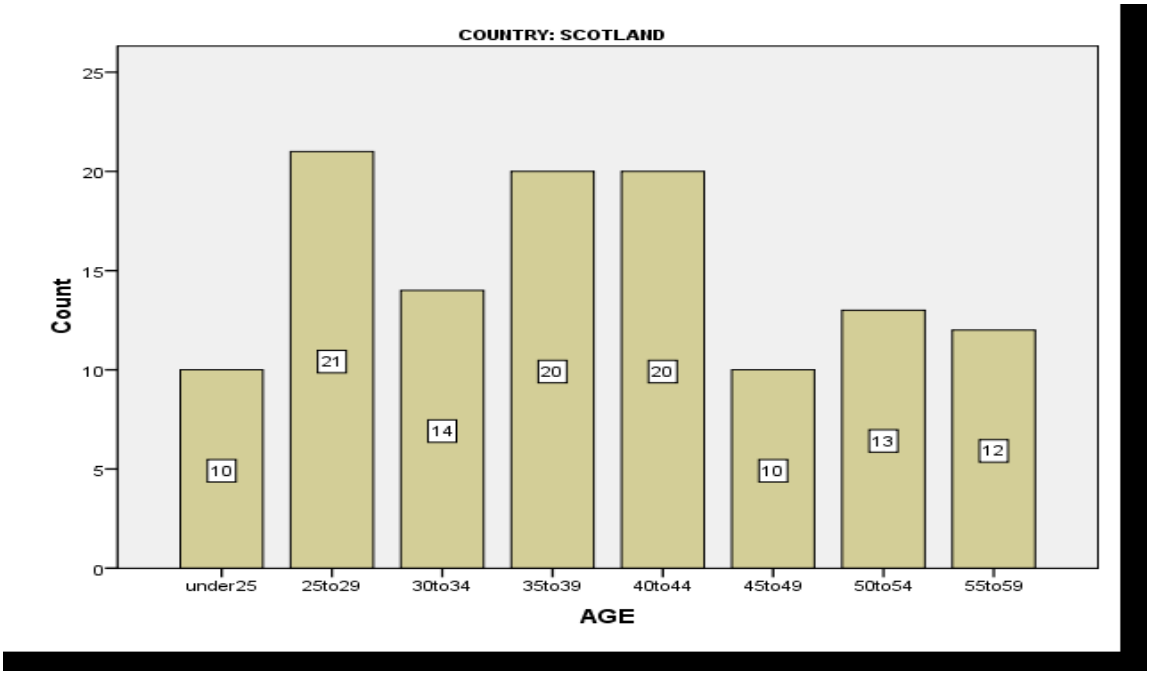

Figure 5. Age distribution within the Scottish sample of teachers and support staff.

When asked about their level of education, most of the Romanian teachers and support staff reported that they hold an undergaduate university degree (24.48 %) or a master degree (24.48 %) See Figure 6.

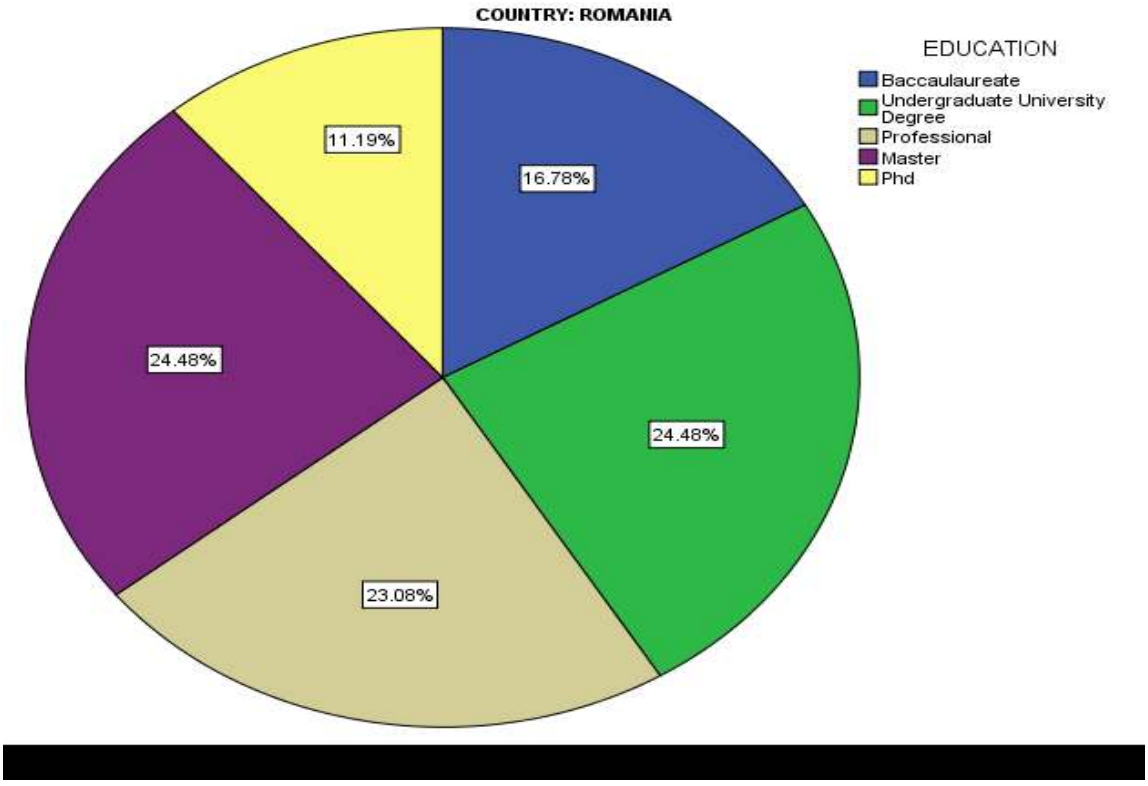

Figure 6. Level of education within the Romanian sample of teachers and support staff.

Similar results were obtained within the Scottish sample, where the majority of teachers and support staff hold an undergraduate university degree (37.5 %) followed by equal percentages of participants who achieved a professional and master degree (26.67 %) See Figure 7.

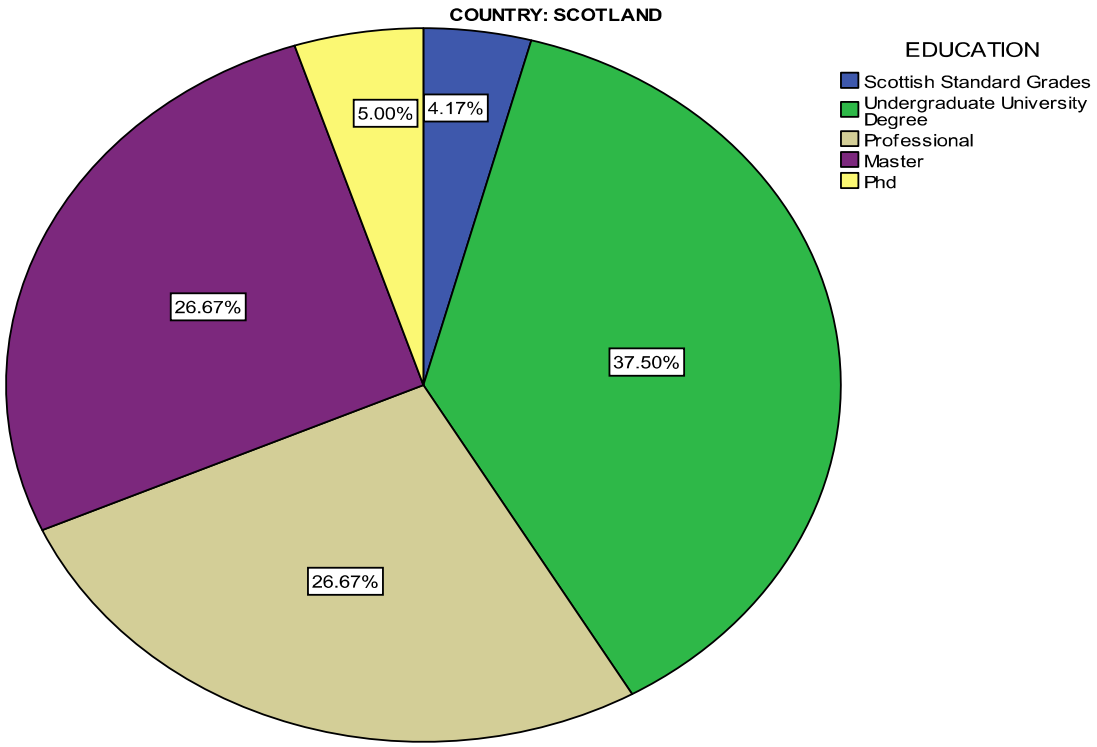

Figure 7. Level of education within the Scottish sample of teachers and support staff.

Furthermore, a considerable number of Romanian teachers and support staff had less than 10 years experience of teaching or working in mainstream education with 12 of them being beginner practitioners with less than one year experience (See Figure 8).

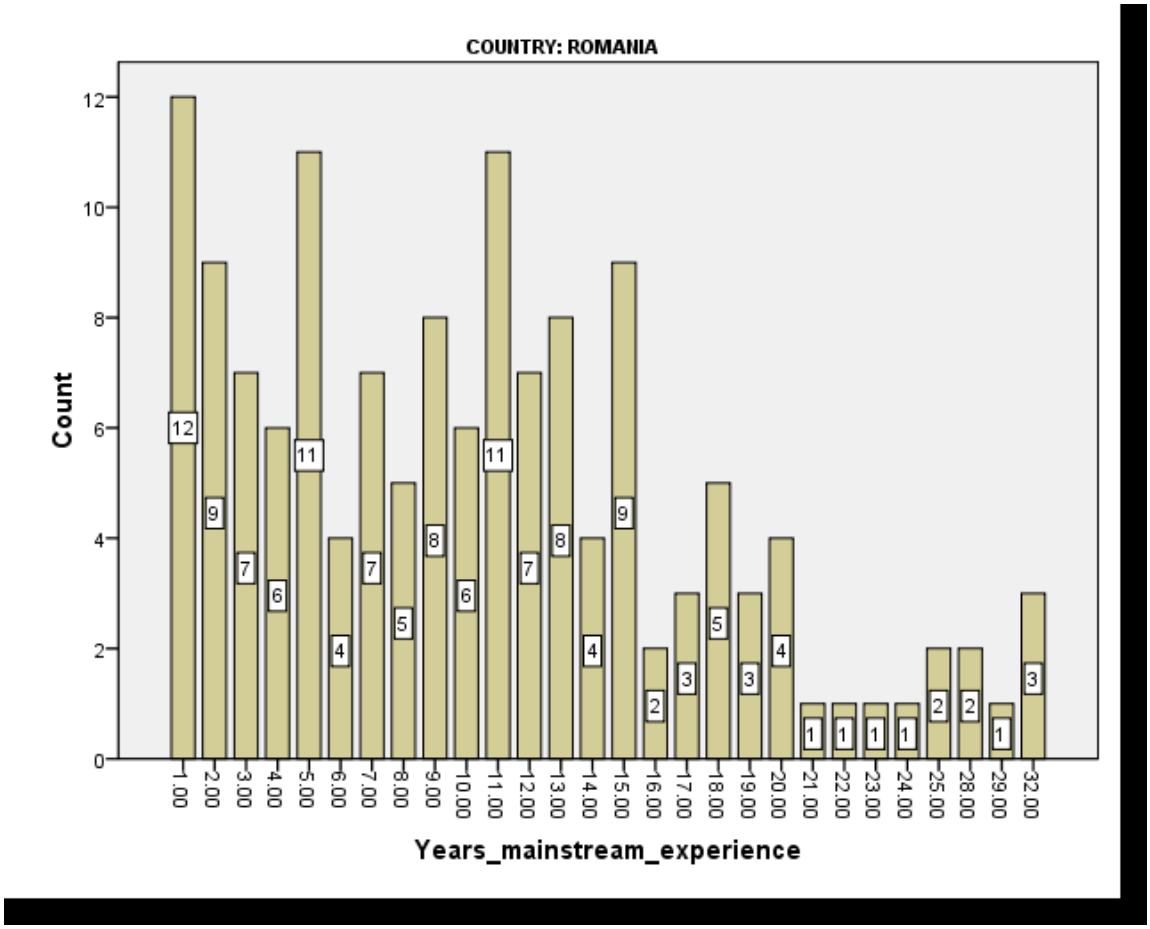

Figure 8. Mainstream experience within the Romanian sample of teachers and support staff.

The years of experience in mainstream education were equally distributed for the Scottish sample. However, 18 participants reported 5 years and respectively 7 years of experience. Interestingly, Figure 9 shows that, as with the Romanian sample, several teachers and support staff (8) had less than one year of professional practice in the classroom.

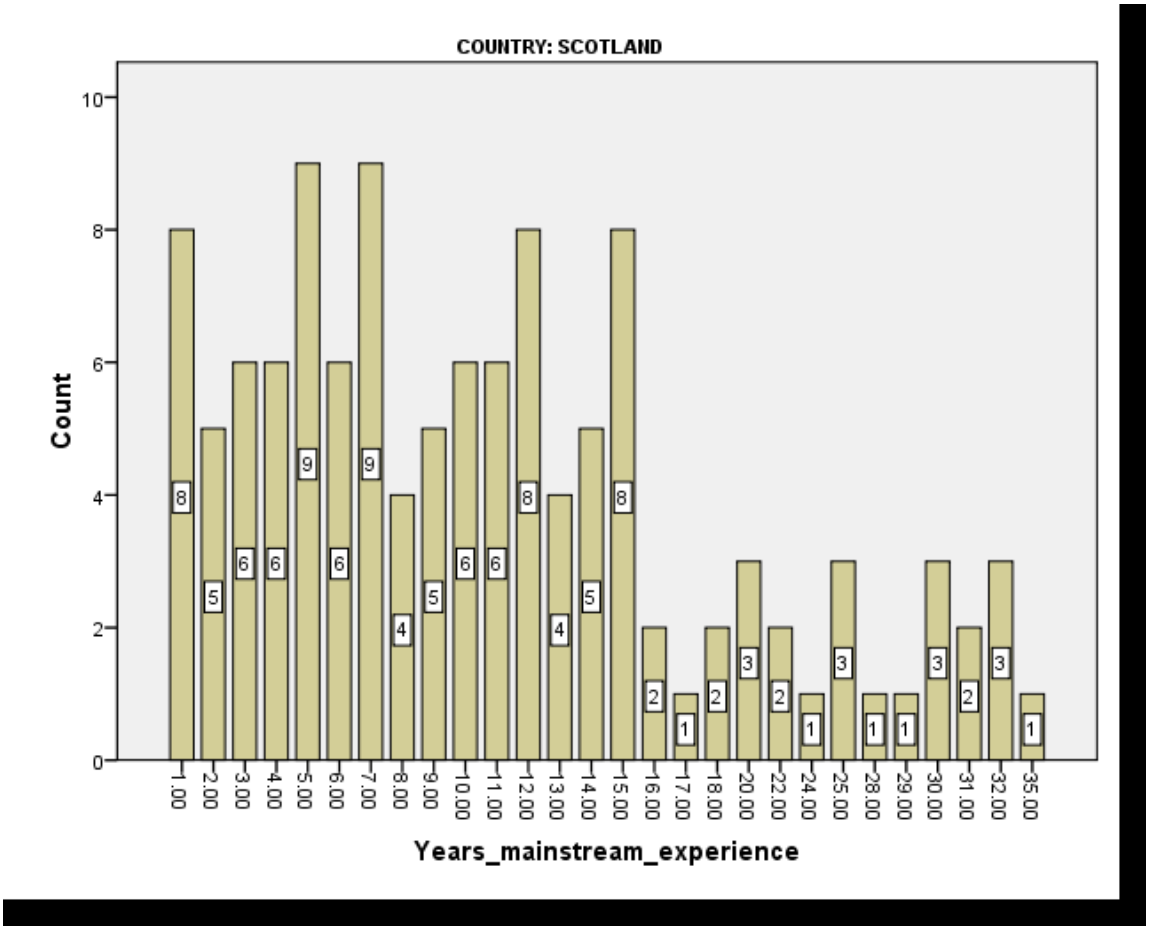

Figure 9. Mainstream experience within the Scottish sample of teachers and support staff.

On the other hand, Figure 10 shows that 53.85 % of the Romanian sample had no experience of teaching in a special education setting.

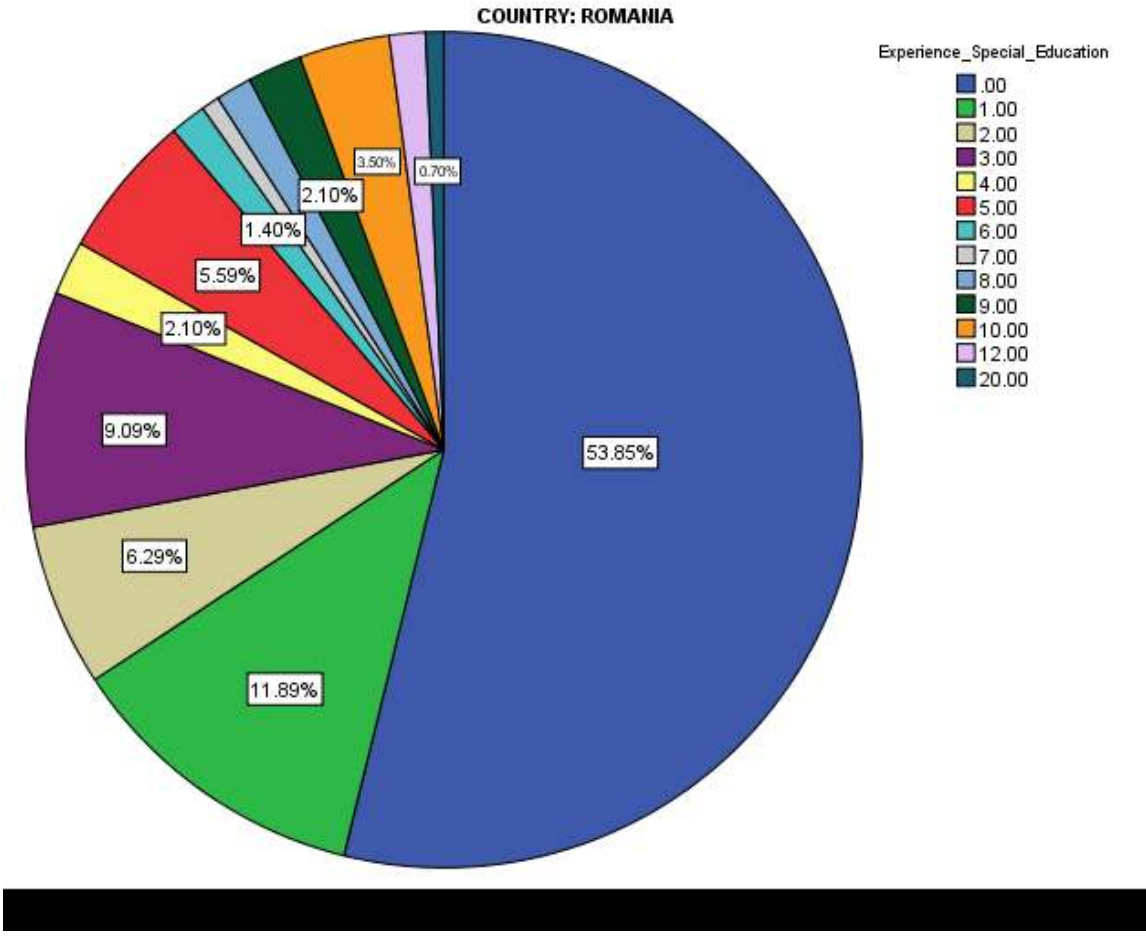

Figure 10. Experience of teaching in special education within the Romanian sample of teachers and support staff.

Similarly, the vast majority of the Scottish teachers and support staff (75.83 %) had no experience of teaching in special education (See Figure 11).

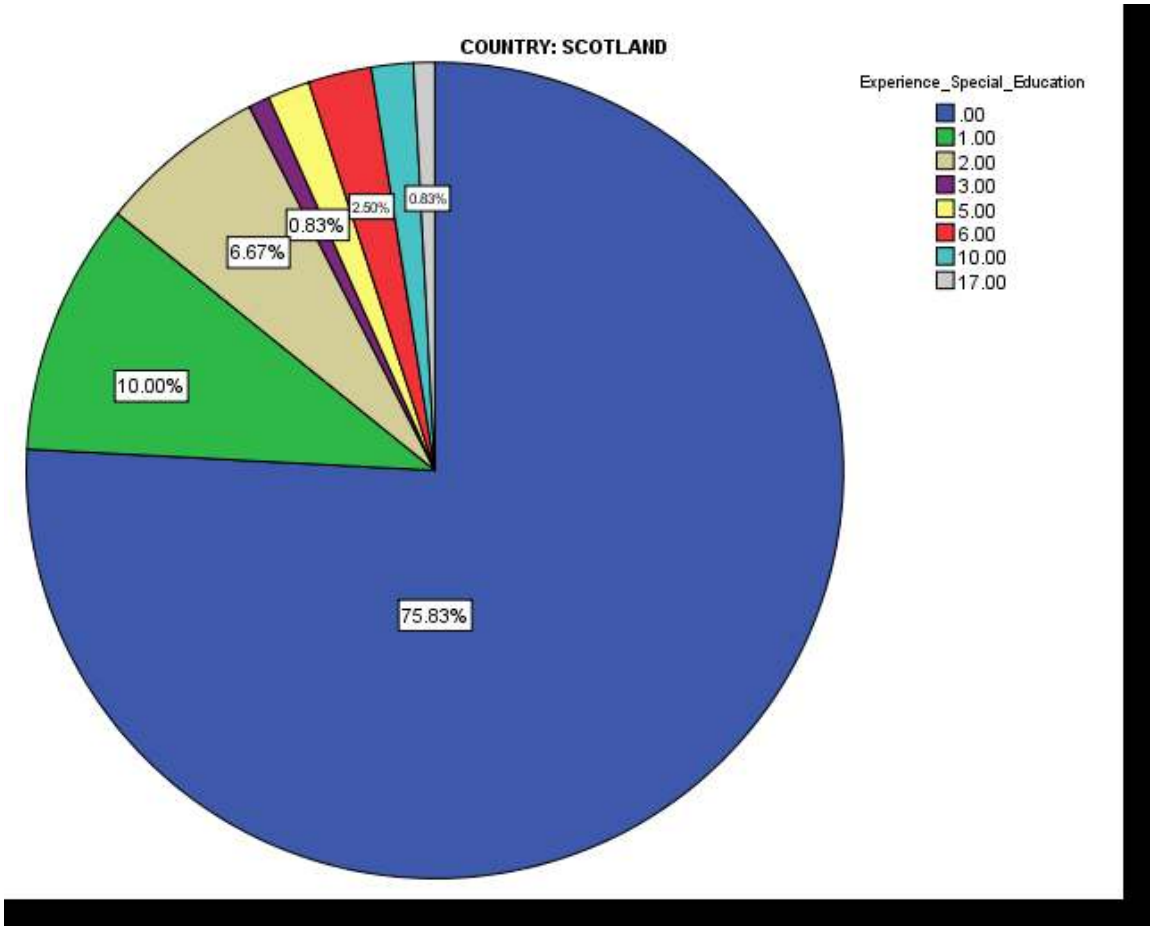

Figure 11. Experience of teaching in special education within the Scottish sample of teachers and support staff.

A significant number of Romanian teachers and support staff (45) indicated that they had never taught or worked with a student diagnosed with ADHD in mainstream education (See Figure 12).

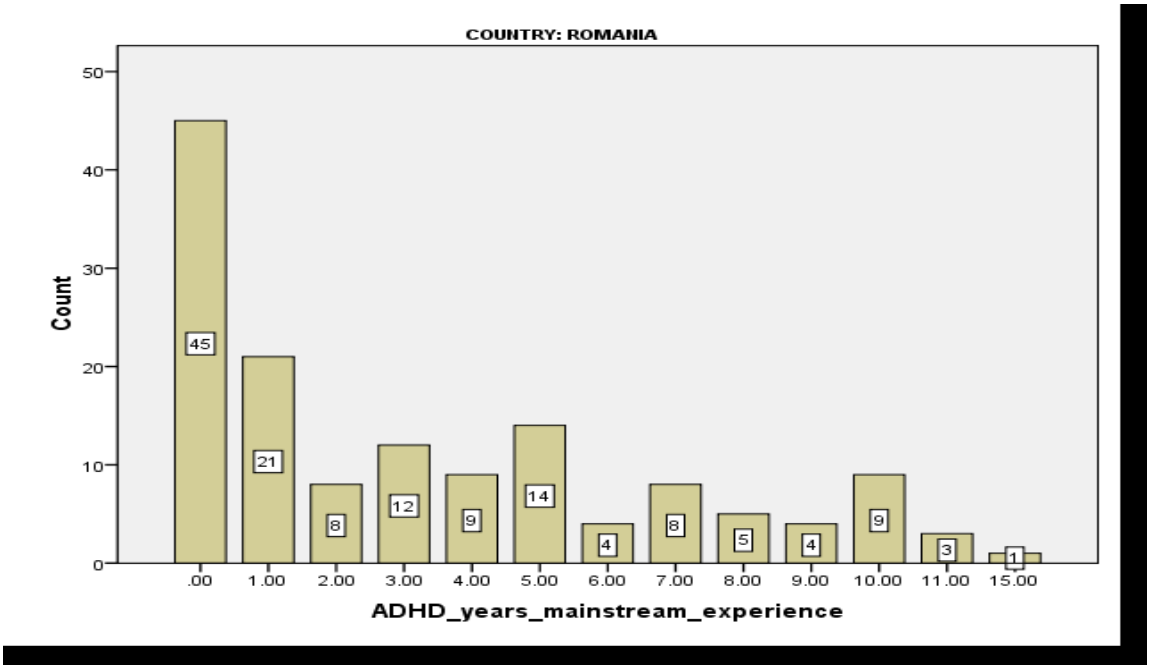

Figure 12. Experience of teaching children diagnosed with ADHD in mainstream within the Romanian sample of teachers and support staff.

Figure 13 shows that relatively similar results were obtained for the Scottish sample, where 42 respondents indicated that they had never taught or worked with a student diagnosed with ADHD in a mainstream environment.

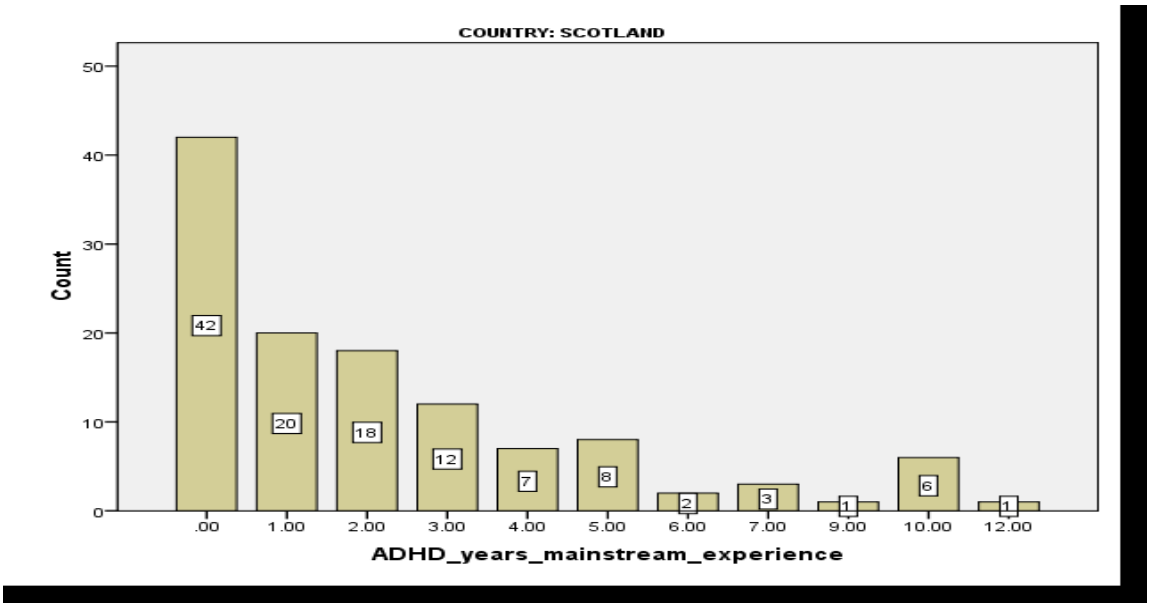

Figure 13. Experience of teaching children diagnosed with ADHD in mainstream within the Scottish sample of teachers and support staff.

The data also showed that most of the Romanian teachers and support staff had never attended a presentation (130 out of 143) or workshop (125 out of 143) about ADHD. Only 45 of them took part in classes or courses specialising in ADHD during their university or college training. Moreover, results indicated that only 42 teachers and support staff actively participated in conferences focused on ADHD. The same response pattern was recorded in Scotland. Most Scottish teachers and support staff had never attended a presentation (92 out of 120) or workshop (112 out of 120) about ADHD. Only 25 took part in classes or courses specialising in ADHD during their university or college training. Lastly, 25 teachers and support staff actively participated in conferences focusing on ADHD.

In order to clarify the reading of the results, Table 4 summarises the demographic data obtained from Scottish and Romanian mainstream teachers and support staff.

Variable		ROMANIA		SCOTLAND	
		Frequency	**Percent**	**Frequency**	**Percent**
AGE	Under 39 years old	78	**54.6**	65	**54.2**
GENDER	Female	143	100	120	100
LEVEL OF EDUCATION	Undergraduate University Degree, Professional and Master Degree	103	**72.1**	109	**90.9**
UNIVERSITY/COLLEGE CLASSES	No classes	98	**68.5**	95	**79.2**
CONFERENCES	No conference	101	**70.6**	95	**79.2**
PRESENTATIONS	No presentation	130	**90.9**	92	**76.7**
WORKSHOPS	No workshop	126	**88.1**	112	**92.3**
		Mean	**Standard Deviation**	**Mean**	**Standard Deviation**
EXPERIENCE IN MAINSTREAM EDUCATION		**10.53**	7.32	**11.44**	8.48
EXPERIENCE IN SPECIAL EDUCATION		**1.97**	3.29	**0.80**	2.29
EXPERIENCE IN TEACHING CHILDREN WITH ADHD IN MAINSTREAM		**3.30**	3.52	**2.28**	3.52

Table 4. Summary of the demographic data obtained from Scottish and Romanian teachers and support staff.

4.1.2. Parents sample description

Both samples of Romanian and Scottish parents consisted of 50 mothers with a similar age distribution. Table 5 shows that the majority of respondents were between 30 and 34 years old.

Age	**Frequency/Romania**	**Frequency/Scotland**
under25	6	4
25to29	9	13
30to34	**24**	**17**
35to39	7	11
40to44	4	5
Total	50	50

Table 5. Age distribution within the Romanian and Scottish sample of parents.

When asked about their level of education, 24 Romanian mothers reported that they hold a Baccalaureate Degree whereas 18 out of 50 Scottish participants had no formal qualifications at the time of the research (See Table 6).

Level	Frequency/Romania	Frequency/Scotland
No formal qualifications	9	**18**
Baccalaureate/ Scottish Standard Grades	**24**	12
Undergraduate University Degree	9	9
Professional Degree	3	8
Master Degree	5	3
Total	50	50

Table 6. Level of education within the Romanian and Scottish sample of parents.

4.2. Statistical results

4.2.1. Results obtained from teachers and support staff

If parents of children diagnosed with ADHD were randomly selected from the medical records, the same process could not be performed for teachers and support staff. In this context, since inferential statistics were based on the assumption of random sampling from populations, the analysis conducted for teachers and support staff group was carried out only for exploratory purposes. No conclusion could be drawn and no results could be generalised. The p values should be used only as guidelines and the results of the statistical analysis should only be reported for the specific research samples, being treated as very tentative until confirmed by subsequent studies.

4.2.1.1. What kind of knowledge about ADHD do teachers and support staff possess?

To address the first research question, descriptive statistics on the total Knowledge of ADHD Scale (KADDS) as well as for each subscale were calculated. Scores were found by dividing the number of correct items by the total number of items and converting the result to a raw score between 0 and 1. Therefore, Table 7 shows that, on the total KADDS, the specific teachers and support staff from Scotland and Romania scored above average: (Mean=0.54, Range=0.13 to 0.94).

KADDS Total scores	N	Minimum	Maximum	Mean
Knowledge Total Score	263	.13	.94	.5430
Valid N (listwise)	263			

Note: KADDS Total score ranges from 0 to 1

Table 7. Mean scores and standard deviation obtained on KADDS by the Romanian and Scottish teachers and support staff.

For the total KADDS, the mean scores for the sample of Romanian teachers and support staff (8.73) were higher than the mean scores for the Scottish sample (8.64). The mean difference between countries was 0.86 and 95 % confidence interval. However, an independent T Test showed that the difference between the scores obtained by participants from Romania and Scotland was not statistically significant: t(261) =0.31, p=0.38. A similar situation was obtained for each of the test subscales, were no significant differences were recorded.

4.2.1.2.1. What kind of knowledge about ADHD do Romanian teachers and support staff possess?

The analysis aimed to examine teachers' knowledge of ADHD within 3 important content areas identified in each cultural context. Therefore, on the total KADDS, teachers and support staff from Romanian sample scored above average (M=0.55, Range=0.13 to 0.81). On the subscales, teachers and support staff scored the highest on the symptoms/diagnosis subscale (M=0.73, SD=0.20) and the lowest on the treatment subscale (M=0.37, SD=0.19). See Table 8

Romanian sample KADDS	N	Minimum	Maximum	M	SD
Total score	143	.31	.81	.5455	.11006
General knowledge	143	.00	.80	.5373	.15998
Treatment knowledge	143	.17	.83	.3734	.18574
Symptoms knowledge	143	.20	1.00	.7273	.20077
Valid N (listwise)	143				

Note: KADDS scores range from 0 to 1

Table 8. Mean scores and standard deviation obtained on KADDS and its subscales by the Romanian teachers and support staff.

An Independent T Test showed that there was no significant difference between the scores obtained by the sample of Romanian teachers and support staff at the total KADDS and its 3 subscales ($p>0.05$). Considering this outcome, teachers and support staff were treated as a single homogeneous research group. Furthermore, in order to investigate the nature of the difference between the mean scores of the participants on the 3 knowledge subscales, a Paired Sample T-Test was carried out. The analysis revealed a significant difference between the mean scores of knowledge about symptoms ($M=3.64$, $SD=1.00$) and general knowledge about ADHD ($M=1.87$, $SD=0.93$), $t(142)=15.47$, $p<0.001$ and between the knowledge about symptoms and knowledge about treatment ($M= 3.22$, $SD=0.96$), $t(142)=3.73$, $p<0.001$, indicating that the sample of Romanian teachers and support staff was more likely to have good knowledge about the diagnosis/symptoms of ADHD than about associated features or treatment. Moreover, the results showed that teachers and support staff reported more knowledge about the associated features of ADHD than knowledge about treatment: $t(142) = 12.61$, $p<0.001$

4.2.1.2.2. What kind of knowledge about ADHD do Scottish teachers and support staff possess?

On the total KADDS, teachers and support staff from the Scottish sample scored above average (M=0.54, Range=0.13 to 0.94). On the subscales, teachers and support staff scored the highest on the symptoms/diagnosis subscale (M=0.73, SD=0.24) and the lowest on the general knowledge about nature, causes and prognosis of ADHD (M=0.35, SD=0.27). See Table 9

KADDS Scottish sample	N	Minimum	Maximum	Mean	Std. Deviation
General knowledge	120	.00	1.00	.3550	.27127
Treatment knowledge	120	.00	1.00	.5389	.20238
Symptoms knowledge	120	.00	1.00	.7267	.23895
Total score	120	.13	.94	.5401	.17184
Valid N (listwise)	120				

Note: KADDS Total score ranges from 0 to 1

Table 9. Mean scores and standard deviation obtained on KADDS and its subscales by the Scottish teachers and support staff.

Similarly with the results obtained in the Romanian sample, an Independent T Test showed that there was no significant difference between the scores obtained by Scottish teachers

and support staff at the total KADDS and its 3 subscales ($p>0.05$). Considering this aspect, Scottish teachers and support staff were also treated as a single research sample.

Next, in order to investigate the nature of the difference between the mean scores of the participants on the 3 knowledge subscales, a Paired Sample T-Test was carried out. The analysis revealed a significant difference between the mean scores of knowledge about symptoms ($M=3.63$, $SD=1.19$) and general knowledge about ADHD ($M=1.77$, $SD=1.36$), $t(119)=11.60$, $p<0.001$ and between the knowledge about symptoms and knowledge about treatment ($M=3.23$, $SD=1.21$), $t(119)=3.75$, $p<0.001$, highlighting that teachers and support staff were more likely to have good knowledge about the diagnosis/symptoms of ADHD than about the associated features or treatment. Moreover, the results showed that Scottish sample of teachers and support staff reported more knowledge about treatment than general knowledge about associated features of ADHD: $t(119) = 10.73$, $p<0.001$.

Summary:

- ✓ *There was no difference between the scores obtained by the samples of Scottish and Romanian teachers and support staff on KADDS and its subscales; (results are reported only as guidelines for the specific research samples)*
- ✓ *There was no difference between the scores obtained by teachers and support staff on KADDS and its subscales;*
- ✓ *Both samples of teachers and support staff scored the highest at symptoms/diagnosis subscale;*
- ✓ *The sample of Romanian teachers and support staff scored the lowest at the treatment subscale whereas their Scottish colleagues had difficulties in answering questions about the nature, causes and prognosis of ADHD.*

4.2.1.3. What are teachers' and support staffs' self-rated attitudes towards ADHD?

Considering the range of the scales, it seemed reasonable to suggest that the mean scores of the participants demonstrated a positive attitude towards ADHD (M=62.29, SD=8.97). As can be seen in Table 10 , on the subscales, teachers and support staff scored the highest on the affective attitude subscale (M=28.85, SD=5.52) and scored the lowest on the behavioural attitude subscale (M=16,48, SD=3.49).

SRAQ	N	Minimum	Maximum	M	SD
Affective attitude	263	12.00	39.00	28.8479	5.51885
Behavioural attitude	263	6.00	25.00	16.4753	3.49022
Cognitive attitude	263	7.00	24.00	16.9049	3.11155
Total score	263	35.00	82.00	62.2281	8.97458
Valid N (listwise)	263				

Note: N=total number of participants, M=Mean, SD=Standard Deviation
SRAQ scores range from Minimum to Maximum

Table 10. Mean scores and standard deviation obtained on SRAQ and its subscales by the Scottish and Romanian teachers and support staff.

Subsequently, a Paired Sample T-Test was carried out in order to investigate the nature of the difference between the mean scores of the participants on the 3 attitudes subscales. The analysis revealed a significant difference between the mean scores of cognitive attitude (M=16.90, SD=3.11) and affective attitude (M=28.85, SD=5.51), $t(261) = 33.23$, $p<0.001$ and between the affective and behavioural attitude (M= 16.48, SD=3.49), $t(261) = 39.27$, $p<0.001$, indicating that teachers and support staff reported more positive affective attitude

towards ADHD than either cognitive or behavioural. The same analysis revealed that there was no difference between the scores obtained by the research sample on the cognitive and behavioural subscale ($p=0.86$).

Although the two samples were not randomly selected, an Independent T Test was carried out for the specific research samples. No conclusion can be drawn and no results can be generalised. For the total SRAQ, the mean scores for the Romanian teachers and support staff ($M=64.72$, $SD=7.55$) were higher than the mean scores for the Scottish Sample ($M=59.26$, $SD=9.64$). The mean difference between countries was 5.46 and 95 % confidence interval. An independent T test showed that the difference between the scores obtained by participants from Romania and Scotland were statistically significant: $t(261)=5.151$, $p<0.05$. For the behavioural subscale, the mean scores for the Romanian teachers and support staff ($M=17.32$, $SD=3.24$) were higher than the mean scores for the Scottish Sample ($M=15.47$, $SD=3.52$). The mean difference between countries was 1.86 and 95 % confidence interval. An independent T Test showed that the difference between the scores obtained by participants from Romania and Scotland were statistically significant: $t(261)=4.44$, $p<0.05$. For the affective subscale, the mean scores for the Romanian teachers and support staff ($M=30.70$, $SD=4.70$) were higher than the mean scores for the Scottish Sample ($M=26.64$, $SD=5.63$). The mean difference between countries was 4.06 and 95 % confidence interval. An independent T test showed that the difference between the scores obtained by participants from Romania and Scotland were statistically significant $t(261)=6.37$, $p<0.05$).

A similar statistical procedure revealed that there were no significant differences between the scores obtained by Scottish and Romanian teachers on the cognitive attitude subscale ($p>0.05$) See Table 11 and Table 12.

	COUNTRY	N	M	SD
Total score	**ROMANIA**	143	64.7203	7.55115
	SCOTLAND	120	59.2583	9.64016
Cognitive attitude	**ROMANIA**	143	16.6993	2.81854
	SCOTLAND	120	17.1500	3.42421
Behavioural attitude	**ROMANIA**	143	17.3217	3.24493
	SCOTLAND	120	15.4667	3.51691
Affective attitude	**ROMANIA**	143	30.6993	4.69797
	SCOTLAND	120	26.6417	5.62975

Table 11. Difference between the scores obtained on SRAQ by the Scottish and Romanian teachers and support staff.

SRAQ				
		t	Df	Sig. (2-tailed)
Total score	Equal variances assumed	5.150	261	.000
	Equal variances not assumed	5.043	223.446	.000
Cognitive attitude	Equal variances assumed	-1.171	261	.243
	Equal variances not assumed	-1.151	230.375	.251
Behavioural attitude	Equal variances assumed	4.444	261	.000
	Equal variances not assumed	4.413	244.981	.000
Affective attitude	Equal variances assumed	6.372	261	.000
	Equal variances not assumed	6.273	232.252	.000

Table 12. Differences between the scores obtained by Scottish and Romanian teachers and support staff on SRAQ and its subscales.

4.2.1.3.1. What are Romanian teachers' and support staffs' self-rated attitudes towards ADHD?

Considering the range of the scales, it seemed reasonable to suggest that the mean scores of the Romanian participants demonstrated positive attitudes towards ADHD (M=64.72, SD=7.55). As Table 13 shows, on the subscales, teachers and support staff scored the highest on the affective attitude subscale (M=30.70, SD=4.70) and scored the lowest on the cognitive subscale (M=16.70, SD=2.82).

SRAQ	N	Minimum	Maximum	Mean	Std. Deviation
Affective attitude	143	16.00	39.00	30.6993	4.69797
Behavioural attitude	143	9.00	25.00	17.3217	3.24493
Cognitive attitude	143	10.00	22.00	16.6993	2.81854
Total score	143	46.00	82.00	64.7203	7.55115
Valid N (listwise)	143				

Table 13. Means and standard deviation obtained on SRAQ and its subscales by the Romanian teachers and support staff.

A Paired Sample T-Test was carried out in order to investigate the nature of the difference between the mean scores of participants on the 3 attitudes subscales. The analysis revealed a significant difference between the mean scores of cognitive attitude (M=16.70, SD=2.82) and affective attitude (M=30.70, SD=4.70), $t(142)=32.03$, $p<0.001$ and between the affective and behavioural attitude (M=17.32, SD=2.34), $t(142)=34.70$, $p<0.001$, indicating

that sample of Romanian teachers and support staff reported more positive affective attitudes towards ADHD than either cognitive or behavioural. The same analysis revealed that there was no difference between the scores obtained by the research sample on the cognitive and behavioural subscale (p=0.65).

43 teachers and support staff indicated that they would benefit from receiving more help from the other teachers and staff from the school, 37 mentioned the family support, 23 considered that the local authority should get more involved while 9 participants believed that the church could have a great impact on their lives.

Interesting results were revealed by comparing the results obtained individually by teachers and support staff. For the total SRAQ, the mean scores for the Romanian support staff (M=67.23, SD=8.64) were higher than the mean scores for the Romanian teachers (M=63.06, SD=7.76). The mean difference between the two groups was 4.17 and 95 % confidence interval. An Independent T Test showed that the difference between the scores obtained by Romanian teachers and support staff was statistically significant: t(141)=3.35, p=0.005. A similar situation was obtained for the behavioural attitude subscale, where the mean scores for the Romanian support staff (M=18.32, SD=2.72) were higher than the mean scores for the Romanian teachers (M=16.66, SD=3.39). The mean difference between the two groups was 1.65 and 95 % confidence interval. An Independent T test showed that the difference between the scores obtained by the sample of Romanian teachers and support staff on the behavioural subscale was statistically significant: t(141)=3.07, p=0.001. The same analysis revealed no difference between the groups scores on the affective (p=0.69) and cognitive attitude subscales (p=0.58).

4.2.1.3.2. What are Scottish teachers' and support staff's self-rated attitudes towards ADHD?

Considering the range of the scales, it seemed reasonable to suggest that the mean scores of the Scottish participants demonstrated positive attitudes towards ADHD (M=59.26, SD=9.64). As Table 24 shows, on the subscales, teachers and support staff scored the highest on the affective attitude subscale (M=26.64, SD=5.62) and scored the lowest on the behavioural attitude subscale (M=15.47, SD=3.52).

SRAQ	N	Minimum	Maximum	M	SD
Affective attitude	120	12.00	39.00	26.6417	5.62975
Behavioural attitude	120	6.00	23.00	15.4667	3.51691
Cognitive attitude	120	7.00	24.00	17.1500	3.42421
Total score	120	35.00	82.00	59.2583	9.64016
Valid N (listwise)	120				

Table 14. Means and standard deviation obtained on SRAQ and its subscales by the Scottish teachers and support staff.

Subsequently, a Paired Sample T-Test revealed a significant difference between the mean scores of cognitive attitude (M=17.15, SD=3.42) and affective attitude (M=26.65, SD=5.63), $t(119) = 18.653$, $p<0.001$ and between the affective and behavioural attitude (M= 15.47, SD=3.52), $t(119)=14.492$, $p<0.001$, indicating that teachers reported more positive affective attitude towards ADHD than either cognitive or behavioural. The same analysis pointed out a significant difference between the mean scores for cognitive and behavioural

subscales, $t(119)=4.95$, $p<0.001$, so that the sample of Scottish teachers and support staff demonstrated more positive cognitive attitude than behavioural attitude.

Furthermore, 45 teachers and support staff reported that they would benefit from receiving more help from the family of children diagnosed with ADHD, 39 mentioned the local authority while 6 participants believed that a better co-operation with other teachers and staff from the school could only be beneficial. An Independent T test showed that there were no significant differences between the scores obtained by the sample of Scottish teachers and support staff on the total attitude test and its 3 subscales ($p>0.05$).

Summary:

- ✓ *Overall, when compared with the Scottish sample, Romanian teachers and support staff revealed more positive attitudes towards ADHD; Romanian teachers and support staff reported more positive affective and behavioural attitude than did the Scottish participants; (results are reported only as guidelines for the specific research samples)*
- ✓ *Both Scottish and Romanian samples of teachers and support staff scored the highest on the affective attitude subscale;*
- ✓ *Scottish teachers and support staff scored the lowest on the behavioural attitude subscale. Within the Scottish sample, no difference was recorded between teachers and support staff;*
- ✓ *The sample of Romanian teachers and support staff scored the lowest on the cognitive attitude subscale; Within the Romanian sample, support staff obtained higher scores on the total SRAQ and on the behavioural attitude subscale than did the primary school teachers;*

4.2.2. Results obtained from parents of children diagnosed with ADHD

4.2.2.1. What kind of knowledge about ADHD do parents posses?

In order to investigate the nature of the difference between the mean scores of the participants from the two countries, an Independent Sample T-Test was carried out. The analysis showed a significant difference between the mean scores obtained by mothers from the Romanian sample (M=0.45, SD=0.09) and the Scottish sample (M=0.54, SD=0.11) on the total KADDS, showing that Scottish mothers reported more knowledge about ADHD than did the mothers from the Romanian sample: $t(98)=4.01$, $p<0.001$. The same analysis showed a significant difference between the mean scores obtained by Romanian mothers (M=0.09, SD=0.07) and Scottish mothers (M=0.19, SD=0.07) on the treatment subscale, pointing out that more knowledge about treatment was recorded within the Scottish sample: $t(98)=7.15$, $p<0.001$.

Although Romanian sample of mothers seemed less knowledgeable overall in the test, they scored higher on the symptoms subscale (M=0.25, SD=0.04) than did the Scottish participants (M=0.22, SD=0.07), $t(98)=2.23$, $p<0.001$. Moreover, the results indicated that there were no significant differences between the scores obtained by the samples of Scottish and Romanian mothers on the general knowledge subscale (p=0.48)

See Table 15 and Table 16.

	KADDS	N	M	SD
Total score	**ROMANIA**	50	.45400	.093344
	SCOTLAND	50	.54000	.114336
General Knowledge	**ROMANIA**	50	.8800	.09822
	SCOTLAND	50	.0200	.09998
Treatment Knowledge	**ROMANIA**	50	.09800	.07622
	SCOTLAND	50	.19300	.07313
Symptoms knowledge	**ROMANIA**	50	.25800	.04848
	SCOTLAND	50	.22400	.07157

Table 15. Means and standard deviation obtained on KADDS and its subscales by the Scottish and Romanian mothers.

KADDS		t	df	Sig. (2-tailed)	Mean Difference
Total score	Equal variances assumed	-4.011	98	.000	-.08500
	Equal variances not assumed	-4.011	94.857	.000	-.08500
General Knowledge	Equal variances assumed	-.706	98	.482	-.00875
	Equal variances not assumed	-.706	97.969	.482	-.00875
Symptoms Knowledge	Equal variances assumed	2.230	98	.028	.02750
	Equal variances not assumed	2.230	77.252	.029	.02750
Treatment Knowledge	Equal variances assumed	-7.152	98	.000	-.10500
	Equal variances not assumed	-7.152	97.492	.000	-.10500

Note: df=degrees of freedom (N-2)

Table 16. Differences between the scores obtained by Scottish and Romanian mothers on KADDS and its subscales.

4.2.2.1.1. What kind of knowledge about ADHD do Romanian parents possess?

On the total KADDS, mothers from the Romanian sample scored lower than average (Mean=0.46, Range=0.25 to 0.63). Table 17 shows that, on the subscales, mothers scored the highest on the symptoms/diagnosis subscale (M=0.25, SD=0.04) and the lowest on the treatment subscale (M=0.09, SD=0.07)

KADDS	N	Minimum	Maximum	Mean	Std. Deviation
Treatment knowledge	50	.00	.25	.0925	.07601
General knowledge	50	.00	.25	.1175	.06139
Symptoms knowledge	50	.13	.31	.2488	.04280
Total score	50	.25	.63	.4588	.09584
Valid N (listwise)	50				

Table 17. Means and standard deviation obtained on KADDS and its subscales by the Romanian mothers.

Further, in order to investigate the nature of the difference between the mean scores of the participants on the 3 knowledge subscales, a Paired Sample T-Test was carried out. The analysis revealed a significant difference between the mean scores of knowledge about symptoms (M=0.25, SD=0.04) and general knowledge about ADHD (M=0.11, SD=0.06), $t(49)=12.38$, $p<0.001$ and between the knowledge about symptoms and knowledge about treatment (M= 0.09, SD=0.07), $t(49)=12.47$, $p<0.001$, indicating that mothers were more

likely to have good knowledge about the diagnosis/symptoms of ADHD than about associated features or treatment. Moreover, the results showed that there were no significant differences between the scores obtained on the general knowledge and treatment subscale (p=0.10).

4.2.2.1.2. What kind of knowledge about ADHD do Scottish parents possess?

On the total KADDS, mothers from the Scottish sample scored above average (M=0.54, Range=0.25 to 0.81). On the subscales, they scored the highest on the symptoms/diagnosis subscale (M=0.22, SD=0.07) and the lowest on the general knowledge subscale (M=0.12, SD=0.06) See Table 18.

KADDS	N	Minimum	Maximum	M	SD
Treatment knowledge	50	.00	.38	.1975	.07071
General knowledge	50	.00	.31	.1263	.06249
Symptoms knowledge	50	.06	.31	.2213	.07598
Total score	50	.25	.81	.5438	.11521
Valid N (listwise)	50				

Table 18. Means and standard deviation obtained on KADDS and its subscales by the Scottish mothers.

In order to investigate the nature of the difference between the mean scores of the participants on the 3 knowledge subscales, a Paired Sample T-Test was carried out. The analysis revealed a significant difference between the mean scores of knowledge about symptoms (M=0.22, SD=0.07) and general knowledge about ADHD (M=0.12, SD=0.06), $t(49)=6.01$, $p<0.001$, indicating that mothers were more likely to have good knowledge about the diagnosis/symptoms of ADHD than about associated features. The results also showed a significant difference between the mean scores obtained on the general knowledge subscale and the treatment subscale (M=0.19, SD=0.07), $t(49)=5.95$, $p<0.001$, pointing out that participants reported more general knowledge about ADHD than about its treatment. Moreover, the results showed that there were no significant differences between the scores obtained at symptoms and treatment subscale ($p=0.11$).

Summary:

- ✓ *The sample of Scottish mothers reported more knowledge about ADHD than did the mothers from the Romanian sample. Furthermore, they were more knowledgeable about the ADHD treatment; (results are reported only as guidelines for the specific research samples)*
- ✓ *Both samples of Scottish and Romanian mothers scored the highest on the symptoms/diagnosis subscale;*
- ✓ *The sample of Romanian mothers scored the lowest on the treatment subscale whereas the sample of Scottish mothers scored the lowest on the general knowledge subscale;*

4.2.2.2. What are parents' self-rated attitudes towards ADHD?

In order to investigate the nature of the difference between the mean scores of the participants from the two countries, an Independent Sample T-Test was carried out. The analysis revealed no significant difference between the mean scores obtained by participants from Romania and Scotland at the total test measuring their attitudes (p=0.66). The same analysis showed no significant difference between the mean scores obtained by the samples of Romanian and Scottish mothers on the cognitive attitude subscale (p=0.33), the behavioural subscale (p=0.25) or the affective attitude subscale (p=0.24) See Table 19.

Table 19. Differences between the scores obtained by Scottish and Romanian mothers on SRAQ and its subscales

SRAQ		T	df	Sig. (2-tailed)
SRAQ Total score	Equal variances assumed	-.406	98	.656
	Equal variances not assumed	-.406	94.117	.656
Affective attitude	Equal variances assumed	2.396	98	.240
	Equal variances not assumed	2.396	77.893	.240
Behavioural attitude	Equal variances assumed	-4.185	98	.250
	Equal variances not assumed	-4.185	93.677	.250
Cognitive attitude	Equal variances assumed	-1.150	98	.330
	Equal variances not assumed	-1.150	96.965	.330

4.2.2.2.1. What are Romanian parents' self-rated attitudes towards ADHD?

Considering the range of the scales, it seemed reasonable to suggest that the mean scores of the Romanian participants demonstrated positive attitudes towards ADHD (M=64.66, SD=6.82). As Table 20 summarises, on the subscales, mothers scored the highest on the affective attitude subscale (M=32.98, SD=4.39) and scored the lowest on the behavioural attitude subscale (M=14.16, SD=3.11).

SRAQ	N	Minimum	Maximum	M	SD
Total score	50	52.00	83.00	64.6600	6.82316
Affective attitude	50	26.00	44.00	32.9800	4.39150
Behavioural attitude	50	7.00	23.00	14.1600	3.11258
Cognitive attitude	50	10.00	25.00	17.5200	3.10523
Valid N (listwise)	50				

Table 20. Means and Standard deviations obtained on SRAQ and its subscales by the Romanian mothers.

Subsequently, a Paired Sample T-Test was carried out in order to investigate the nature of the difference between the mean scores of the participants on the 3 attitudes subscales. The analysis revealed a significant difference between the mean scores of cognitive attitude (M=17.52, SD=3.10) and affective attitude (M=32.98, SD=4.39), $t(49)=21.47$, $p<0.001$, between the affective attitude and behavioural attitude (M= 14.16, SD=3.11), $t(49)=24.60$, $p<0.001$, and between the behavioural and cognitive attitude: $t(49)=6.32$, $p<0.001$, indicating that mothers reported more positive affective attitudes towards ADHD than

either cognitive or behavioural, whereas the cognitive attitudes were considerably higher than the behavioural ones.

Furthermore, 22 mothers indicated that they would benefit from receiving more help from others members of the extended family, 14 mentioned school co-operation, 7 relied on church support, 6 considered that the local authority should get more involved while 5 participants believed that various parents' groups are of a great significance and impact.

4.2.2.2.2. What are Scottish parents' self-rated attitudes towards ADHD?

Considering the range of the scales, it seemed reasonable to suggest that the mean scores of the Scottish participants demonstrated positive attitudes towards ADHD (M=65.28, SD=8.38). As can be observed in Table 21, on the subscales, mothers scored the highest on the affective attitude subscale (M=29.98, SD=7.69) and scored the lowest on the behavioural attitude subscale (M=17.10, SD=3.87).

SRAQ	N	Minimum	Maximum	M	SD
Total score	50	51.00	95.00	65.2800	8.38375
Affective attitude	50	15.00	57.00	29.9800	7.68909
Behavioural attitude	50	8.00	24.00	17.1000	3.87167
Cognitive attitude	50	12.00	25.00	18.2000	2.79942
Valid N (listwise)	50				

Table 21. Means and Standard deviations obtained on SRAQ and its subscales by the Scottish mothers.

A Paired Sample T-Test was also carried out in order to investigate the nature of the difference between the mean scores of the participants on the 3 attitudes subscales. The analysis revealed a significant difference between the mean scores of cognitive attitude (M=18.20, SD=2.80) and affective attitude (M=29.98, SD=7.69), $t(49)=9.94$, $p<0.001$, and between the affective and behavioural attitude (M=17.10, SD=3.87), $t(49)=9.59$, $p<0.001$, indicating that parents reported more positive affective attitude towards ADHD than either cognitive or behavioural. The same analysis revealed that there were no differences between the scores obtained by the research sample on the cognitive and behavioural subscale ($p=0.51$). Furthermore, 23 mothers indicated that they would benefit from receiving more help from school staff, 13 mentioned the parents' groups, 11 considered that the local authority should get more involved while only one participant relied on the church's support.

Summary:

- ✓ *No difference was recorded in terms of attitudes revealed by the samples of Scottish and Romanian parents; (results are reported only as guidelines for the specific research samples)*
- ✓ *Both Scottish and Romanian samples of parents scored the highest on the affective attitude subscale and the lowest on the behavioural attitude subscale.*

4.3.2. Selecting the sample of teachers, support staff and parents for the semi-structured interviews

After the questionnaires' responses were introduced in SPSS, the total scores obtained on the self-report questionnaire were calculated for each participant. Therefore, for the next phase of the research, the sample included:

- ✓ 3 teachers and 3 support staff who scored the highest, the lowest or average from Scotland and Romania
- ✓ 2 mothers who scored the highest, one mother who scored average and 2 mothers who scored the lowest from Scotland and Romania

Table 22 presents the cases selected for the subsequent interviews and the scores obtained:

Table 22. Selection of participants for the semi-structured interviews.

Scotland				Romania			
Teachers		Support staff		Teachers		Support staff	
Id	Score	Id	Score	Id	Score	Id	Score
1	46	1	42	1	55	1	55
2	67	2	70	2	76	2	71
3	93	3	95	3	91	3	94

Mothers		Mothers	
Id	Score	Id	Score
1	39	1	41
2	39	2	43
3	54	3	59
4	85	4	90
5	91	5	95

5. Interpreting the results of the self-report questionnaire

5.1. Research questions 1: What kind of knowledge about ADHD do teachers, support staff and parents possess?

In order to understand how ADHD was conceptualised in two different cultural contexts, it was necessary to describe and compare the knowledge patterns, pointing out the main similarities and differences between the countries. However, there was a dearth of empirical studies reporting exclusively on the knowledge of parents, primary school teachers and support staff towards the associated features, symptoms/diagnosis and treatment of ADHD. Data from the present investigation showed that overall, Scottish and Romanian teachers' and support staff's level of knowledge about ADHD was adequate although there was considerable room for improvement. On the other hand, when referring to the parents' sample, the results pointed out that mothers from Romania scored lower than average while Scottish participants were slightly above average.

For the knowledge test, no difference was recorded between the Romanian and Scottish samples of teachers and support staff. A similar situation was obtained for each of the test subscales. No significant differences were obtained. Furthermore, since there were no significant differences between the scores obtained by teachers and support staff at the total KADDS and its 3 subscales, the interpretations were to be performed for the whole sample.

A different situation was recorded when analysing the results obtained from mothers of children diagnosed with ADHD. For the knowledge test, the sample of Scottish mothers reported more overall knowledge about ADHD and more accurate knowledge about treatment than did the Romanian participants. Interestingly, although Romanian mothers seemed less knowledgeable overall in the test, they scored higher at the symptoms/diagnosis subscale.

These findings, along with those of previous studies, highlighted that there were knowledge deficits across subdomains for all the participants who enrolled in this study. An item based analysis was carried out to see which statements were answered most correctly and what are teachers', support staff's and parents' biggest misconceptions. In order to differentiate between knowledge, lack of information and misconceptions, the pattern of correct, don't know and incorrect answers were identified and analysed. The troubling issues identified in the individual item analysis were presented only for the subscales that elicited the most important differences between the two cultural settings.

5.1.1. *Knowledge about Symptoms/Diagnosis*

Both Romanian and Scottish samples of teachers, support staff and parents demonstrated good knowledge regarding symptoms/diagnosis. These results are supported by the limited literature pertaining to this subject. For example, Macey (2005) demonstrated that primary school teachers were able to identify diagnostic symptoms of ADHD with an accuracy of 83 %. Similarly, Sciutto, Terjesen, & Bender-Frank (2000) reported that more than 80 % of the teachers were knowledgeable about symptoms and the diagnosis of ADHD as it relates to the DSM-IV- TR criteria. Also contributing to the argument was Perold, Louw, & Kleynhans's (2010) study that revealed that teachers were very knowledgeable about the hallmark symptoms of ADHD, with more than 75 % of the respondents correctly identifying the symptoms of distractibility, fidgeting, difficulties with organisation, as well as of the primary clusters of ADHD symptoms.

These results are explained by Herbert and Dalrymple (2004), who argued that, as a prototypical externalising disorder, ADHD is recognised and referred for intervention frequently. Teachers and parents are usually aware of the symptoms and the signs to look for. ADHD is characterised by inattention, hyperactivity, and impulsivity. According to Curatolo, Paloscia, D'Agati, Moavero, & Pasini (2009), these components act in concert to generate the symptoms of the disorder, including failure to complete a started task, being engaged in several activities at once, dissatisfaction, low frustration threshold, poor social judgement or low capacity to concentrate, along with difficulty in maintaining focus. When they were questioned about their knowledge on this subject, the majority of the Romanian and Scottish participants knew that students diagnosed with ADHD are frequently

distracted by irrelevant background noise and often fidget in their seats. Respondents were also knowledgeable about the problems children diagnosed with ADHD have with organisational skills, difficulties scientifically confirmed by Barkley (2005) and DuPaul and Stoner (2003) who found that children diagnosed with ADHD are less skilled in the use of complex problem solving strategies and organisational skills. Furthermore, participants agreed with the fact that a diagnosis of ADHD involves inattention, hyperactivity and impulsivity that needs to manifest both at home and at school.

These results could be partly explained on the basis of the increasing rates of ADHD diagnosis which affects the academic and social functioning of the children. On one hand, as Small (2003) pointed out, teachers tend to perform better at these items because they are often faced with the consequences of the disorder, and frequently questions about children's symptoms relate to what they directly observe in the classroom. Skills such as sitting still, listening, obeying, cooperating, following directions and completing assignments are an integral part of being successful in school. Since teachers are expected to refer, manage and support children diagnosed with ADHD, a good level of knowledge about symptoms is understandable. The lack of significant differences in knowledge of symptoms might also reflect an emphasis on the clinical presentation of ADHD in university training courses.

On the other hand, ADHD is not only a school day disorder. The diagnosis is linked to many problems within the family, affecting every aspect of children's lives. Characteristics such as forgetfulness and disorganisation cause problems at school as well as at home. Authors like Bailey (2010), Harpin (2005) and Klassen, Miller, & Fine (2004) concluded that the presence of a child diagnosed with ADHD could result in

increased likelihood of disturbances to family and marital functioning, disrupted parent-child relationships, reduced parenting efficacy, and increased levels of parental stress. Presumably, the disruptive nature of the disorder creates a stressful environment for all involved, leading to more immediate attention from mothers and careers. Because mothers do in fact observe manifestation of their child's condition through school-related activities performed at home and general behaviour such as chores or play activities, the items most commonly answered correctly by mothers were also related to the core characteristics of ADHD.

However, a closer inspection of the symptoms checklists presented by DSM-IV-TR and ICD-10 reveals a strong link between ADHD-like symptoms and classroom performance taking into consideration that forgetting things, completing tasks, and sustaining attention are critical behaviours associated with academic achievement. Rather than simply concluding that participants were knowledgeable about the symptoms of ADHD just because they interact more with the children in the classroom and at home, it could also be argued that teachers, support staff and parents were often too focused on setting external goals for the children. For instance, teachers might be the first to notice signs of academic, behavioural, or emotional difficulties just because these difficulties prevent the student diagnosed with ADHD from making the expected educational gains. As a result, symptoms specific to ADHD are likely to be central to teachers' appraisal of student's progress and targets of teacher attention. They spend a great deal of time measuring and grading academic work and, as a result, were likely to demonstrate the greatest assessment knowledge and expertise in related areas. In the same way, mothers seemed to expect children's compliance with structure, order and routines without being

able to tolerate minor deviations from their expectations. The basic assumption behind the high value placed on accomplishing goals was that the ADHD symptomatology was a true and reliable indicator of academic productivity, behaviour, and achievement. Indeed, as Kapalka (2005) suggested, some mothers appear to focus more on the acting out behaviours of ADHD children (e.g. hyperactivity) while not paying enough attention to more in-depth difficulties which are not so easily noticeable. These perfectionist mothers are more likely to attend to the symptoms of ADHD, while spending less time addressing what actually causes the manifestation of the symptoms within the child

The results obtained on KADDS might indicate that children's overall achievement was the primary impetus for teachers', support staff's and parents' concern and ultimately the driving force for the development of schemas of ADHD. Such perspectives reflected the medical model of disability where adults perceived children only in terms of their ADHD symptoms. Many of the stigmatising beliefs and negative attributes, like disobeying, disrupting, or underachieving, might impede teachers and parents in making a distinction between the child's identity and the disorder itself.

5.1.2. *Knowledge about Treatment*

One of the most telling results of the present study was that, although the sample of Romanian teachers, support staff and parents showed high overall knowledge about ADHD, their understanding of the treatment was limited when compared to their Scottish counterparts. Many items in the treatment subscale were answered with *don't know* responses, indicating ignorance rather than false knowledge. The total scores and percentages of *correct, don't know and incorrect* answers to individual treatment questions were also computed in order to differentiate between the concepts on which there was a lack of knowledge or misconceptions. For example, some educators from the Romanian sample did not know what the most common type of medication used to treat children diagnosed with ADHD is, were not aware about the role and efficacy of cognitive behaviour therapy in reducing symptoms associated with ADHD and had no information about methylphenidate (Ritalin) as a treatment for ADHD. Furthermore, mothers from the Romanian sample were not sure if punishment could be used to reduce the symptoms associated with ADHD and incorrectly believed that individual psychotherapy is sufficient for the treatment of most children diagnosed with ADHD. Parents who believe that their child's difficulties are the result of a biological issue were more likely to seek medical services that might provide medication, whereas mothers who considered that ADHD aroused purely from social factors or child-rearing tried using punishment as an immediately effective method in changing the child's behaviour.

These findings might indicate that the conceptualisation of ADHD was not consistent throughout the responses. For instance, initially Romanian teachers, support staff

and mothers embraced the medical model of ADHD, being extremely accurate in identifying the pathological symptomatology pertaining to ADHD. Unexpectedly, in the next part of the questionnaire, they lacked more in-depth information about ADHD treatment and reported inconsistent aetiological bases. In this context, some commonly-held myths about ADHD might have not been yet debunked. Although not discernible from the data alone, it is plausible that Romanian teachers and support staff might dismiss the importance of having information about treatment procedures as a result of differing pedagogical orientations. Treatment information may not be taught to teachers because, technically, they do not treat ADHD (Anderson, Watt, Noble, & Shanley, 2012).

The present findings are strongly supported by the literature in the field. For example, Snider, Busch, & Arrowood (2003) and Shaw et al., (2002) suggested that teachers could be more fully aware of the possible side effects of methylphenidate, arguing that if teachers knew more about the side effects of stimulant medication, perhaps they could more carefully weigh the pros and cons of pharmacological solutions for behaviour problems. Akram, Thomson, Boytera, & McLarty (2009) reported that the majority of qualified and student teachers were aware that medication is not a cure for ADHD but just under half of both cohorts also incorrectly believed that a positive response to stimulants was indicative of underlying ADHD. In the same way, other prior studies (e.g. Ghanizadeh, Bahredar, & Moeini, 2006) showed that 69.9 % of teachers and parents were unaware of Ritalin whereas Brook, Watemberg, & Geva (2000) obtained a rate of 15.2 % for the same target population. These findings are noteworthy considering the prevalence of ADHD among school-age children and the fact that the lack of teachers' knowledge about treatment could represent one of the greatest obstacles in attending to the needs of this

population. As DuPaul, Weyandt, O'Dell, & Varejao (2009) ascertained, it is very likely that problems associated with students diagnosed with ADHD would be compounded when they are placed in a classroom with teachers who show a low level of knowledge of effective treatments. Educators could start making themselves familiar with the comprehensive therapeutic approach to ADHD treatment so that they could effectively communicate with both the family and medical personnel regarding the students' overall school performance (Forness & Kavale, 2000).

On the other hand, Scottish participants seemed to be more knowledgeable about the pharmacological intervention for the disorder. More than half of these respondents were quite well informed that stimulant drugs are the most common type of drug used to treat children with ADHD, psychotherapy alone is not sufficient for the treatment of most ADHD and punishment does not reduce the symptoms of ADHD. However, several Scottish mothers revealed misconceptions related to some complementary and alternative forms of interventions for ADHD. For instance, the majority of mothers from the Sccotish sample falsely believed that reducing dietary intake of food additives is generally sufficient in treating ADHD, adopting a more mystical conceptualisation of ADHD. This misconception might result in the perception that children are less susceptible because sugar intake, and thus the disorder, can be controlled. As Yeh et al., (2005) also concluded, if respondents believed that the child's problems originated from sociological or spiritual causes, or from a natural disharmony, finding information about treatment might be perceived as a less relevant activity. Furthermore, according to Stormont and Stebbins (2005), if parents agree that ADHD is caused by diet, that belief might provide false hope

for a quick cure which could delay empirically supported treatments and interventions that have been proven effective.

These schemata might suggest that the sample of Scottish parents and teachers conceptualised ADHD as a medical condition. Higher levels of treatment knowledge might be associated with inappropriate medicalisation of family and education, where social rather than medical interventions might be more appropriate. According to Halasz and Vance (2002), conceptualising ADHD as a medical condition could be comforting but it also reifies ADHD as an internal object that has so far not been proven to exist. In this context, the general acceptance of the medical model led teachers and parents to find out more about the psychostimulant treatment of ADHD. Medication might often be an important part of the comprehensive treatment of an individual with ADHD, but it is not sufficient to address the problems associated with the disorder. On the other hand in Scotland, taking into consideration the increases in methylphenidate and amphetamine production during the past decade and possibly the highly publicised and accepted notion that ADHD is neurologically based, it was likely that teachers and parents would be knowledgeable about the categories of medication and its beneficial and known side effects. Teachers, support staff and parents in the Scottish sample might possess greater knowledge and skills around working with medication due to having more training in relation to working with individualised interventions. Stimulant medication, by far the most prescribed medication in relation to ADHD, has the most beneficial effect mainly during school hours. In contradistinction to Romanian teachers, Scottish educators often have the responsibility to administer and monitor the treatment during the day, which could confer upon them more knowledge about the treatment technicalities.

5.1.3. *Knowledge about the Associated Features*

Romanian participants reported accurate knowledge about the nature, causes and prognosis of ADHD. On the other hand, Scottish teachers, support staff and parents had more knowledge about treatment but underperformed at questions relating to the associated features of ADHD. An item based analysis was carried out in order to elucidate what questions were associated with either lack of information or false beliefs. If we refer to the sample of teachers and support staff drawn from Scotland, the majority of them were aware that children diagnosed with ADHD show some degree of poor school performance but are not eligible for placement in special education. However, they also endorsed several myths and misconceptions. For example, slightly more than half of the teachers and support staff did not know that children with ADHD are more distinguishable from non-ADHD children when they are involved in a structured activity rather than in a free play situation.

In terms of misconceptions and false beliefs, the sample of Scottish teachers and support staff stated that the prevalence of ADHD is equivalent in males and females although DSM IV TR (2000) provides evidence that the disorder is more frequent in males (9.2 %) than in females (2.9 %). Maybe the most telling result is the fact that Scottish teachers and support staff reported that depression is not characteristic for students with ADHD. The inconsistency in the ADHD conceptualisation was reflected again in the fact that teachers and support staff were knowledgeable about the ADHD like symptoms and psychostimulant treatment, but lacked more in depth additional information. Many studies showed that a remarkable number of children diagnosed with ADHD encounter multiple problems in their everyday lives and might feel despair because of their incapacity to cope

with the school tasks and challenges. These manifestations are not that evident during the school interaction, and for this reason teachers often fail to recognise depression, an important interfering internalising behaviour associated with ADHD. On the other hand, in Scotland, teachers switch grade and levels every few years either by personal request or by administrative recommendation. Teachers are not given the possibility to see how students behave and express themselves during a longer period of time and therefore they might acquire just superficial knowledge. However, acknowledging the existence of co-occurring affective difficulties is critical for providing optimal assessment and intervention strategies for school-age children with ADHD. Moreover, if these problems remain unidentified and ignored, young people with ADHD are at even greater risk for negative outcomes such as low self-esteem, school failure, substance abuse, delinquency and even incarceration.

The following discussion concentrated on Scottish mothers who also hold many different misconceptions related to the general information about the causes, nature and prognosis of ADHD. Firstly, most of the *don't know* answers were attributed to the question of whether the prevalence of ADHD diagnosis is equivalent in males and females. But one of the most interesting and revealing results was the fact that the majority of Scottish mothers stated that a diagnosis of ADHD makes a child eligible for placement in special education.

Having a child affected by ADHD frequently increases family-school interactions. According to Bussing Gary, Mills, & Garvan (2003), schools should represent a natural point of contact, a source of cues related to the child's behaviour and a source of recommendations for parents. However, mothers from the Scottish sample seemed to be unaware of the policies of inclusive education and the school services that are potentially

relevant in a mainstream classroom. Together, these findings suggested a potential disconnect between Scottish families and the school system that might lead mothers to mistakenly identify ADHD as needing specialized educational care. Based on the avoidance of anticipated negative experiences, one plausible explanation for the decreased communication is the phenomena of mutual withdrawal (Luster & McAdoo, 1994) or the disconnected encounters (Dennis, Davis, Johnson, Brooks, & Humbi, 2008). In this context, mothers' conceptualisation of ADHD could affect the care sought for their children and the level of co-operation with school and health systems. The belief that misbehaviour is caused by a unified, biological condition might determine mothers to invoke medicalised interpretations which would ultimately guide their decision about what type of education their children should pursue.

5.2. Research question 2: What are teachers', support staff's and parents' attitudes towards ADHD?

The statistical analysis showed that Romanian and Scottish samples of teachers', support staff's and parents' scores on SRAQ were almost entirely on the positive side of the continuum, suggesting predominantly positive attitudes toward children diagnosed with ADHD. Romanian teachers and support staff scored the highest on the affective attitude subscale and the lowest on the cognitive attitude subscale. On the other hand, teachers and support staff from Scotland scored the highest on the affective attitude subscale and scored the lowest on the behavioural attitude subscale. The statistical analysis also showed that for the attitude test, the sample of Romanian teachers and support staff had more positive

affective and behavioural attitude than did the Scottish ones. Moreover, within the Romanian sample, the support staff obtained higher attitudinal scores than the general education teachers.

On the other hand, both samples of parents scored the highest on the affective attitude subscale and the lowest on the behavioural attitude subscale. There was no difference between the participants from the two countries on the total attitudinal test and on behavioural, cognitive and affective attitude subscale.

5.2.1.*Cognitive attitude*

Although the differences between the Romanian and Scottish samples were not significant in relation to their cognitive attitude, an exploratory item analysis showed very interesting results. In relation to the analysis of teachers' and support staff's responses, a considerable number of Romanian teachers and support staff agreed with the statements that students diagnosed with ADHD are using the diagnosis as an excuse for being lazy, and that the behaviour of students with diagnosed ADHD would set an undesirable example for the other classmates. They reported negative views about the abilities, limitations and quality of life of students. These findings are in line with Anderson, Watt, Noble, & Shanley's (2012) study which pointed out that Australian teachers had stereotypical and unfavourable beliefs. In this context, a diagnostic label such as ADHD had practical implications for children in the classroom. Bekle (2004) found that teachers' attitudes towards students are generally more negative when children have a diagnostic label than when they are perceived to be average in their overall achievement and abilities. Moreover,

if teachers believe that students are lazy and exhibit a bad influence on the rest of the class, they would also tend to criticise them more and praise them less. As Smith (2006) ascertained, educators who assume that children diagnosed with ADHD are simply naughty, lazy or misbehaving and treat them as if they do not even belong in class, would not be able to form relationships with the students, support positive learning behaviours or build an effective learning community in the classroom. These stereotypes remain within the deficit orientation that limits their thinking and focus the attention on the child's supposed inadequacies.

Furthermore, many primary school teachers and support staff in the Romanian sample were uncertain of, or disagreed with the benefits of inclusion. The inspection of the results on the cognitive subscale indicated that teachers and support staff generally believed that children diagnosed with ADHD should not be taught in the regular school system. In this sense, there are very few studies particularly interested in teachers' attitudes towards the inclusion of students diagnosed with ADHD. The majority of researchers in this field choose to investigate views, opinions and beliefs about the inclusion of children with additional support needs in ordinary schools. For instance, DeBettencourt (1999) concluded that the majority of teachers who were not currently participating in inclusive programmes, had strong negative feelings about inclusion and felt that decision-makers were out of touch with classroom realities. Hammond and Ingalls (2003) also reported that many general education teachers in the United States were not committed and did not support the concept of inclusion, feeling unprepared to manage tasks needed to support inclusive education. Furthermore, as reported by Changpinit, Greaves, & Frydenberg (2007), Thai teachers were less accepting of students who exhibited various degrees of externalised behaviour, being

less knowledgeable about problem behaviour management, roles of paraprofessional teachers and inclusion characteristics.

Indeed, as Smith (2006) highlighted, the medical model of disability often suffocates the efforts of those who profess to support inclusion yet struggle with practices that might enable any student to participate fully in society. After becoming a member of the European Union, Romanian schools have tried to adopt the model of an educational system which is currently applied in other developing countries but would not necessarily prove to be effective in a completely different cultural context. This is the reason why the present results might refer to a failure of the Romanian educational system to carry out integration programmes and support systems for children diagnosed with ADHD and to implement them appropriately.

The results portrayed a completely different situation within the Scottish sample of teachers and support staff. The mean scores on the cognitive attitude subscale were relatively high, showing that educators did not believe that students with ADHD are using the diagnosis as an excuse for being lazy or that their behaviour will set an undesirable example for classmates. Although the educational inclusion of children with ADHD has long been a topic of controversy, teachers and support staff from the Scottish sample generally believed that children with ADHD should be taught in the regular school system. Such findings are in line with studies in other countries like Botswana (e.g. Mangope, 2002), Ghana (e.g. Bawa, Kuyini, & Mangope, 2011) and the United States (e.g. Villa, Thousand, & Chapple, 1996), studies that yielded results which favoured the inclusion of children with additional support needs in mainstream classrooms.

Again, these patterns might reflect the fact that the Scottish educational system has a long history of focusing on children with additional support needs and the fact that inclusion is a widely studied topic of interest. Greater or lesser familiarity with the experience of inclusion has also influenced the degree of teachers' attitudes across the two samples. In Scotland, the educational programmes were directed towards integration of such children producing teachers with better training and more positive experiences in relation to children diagnosed with ADHD. Scottish teachers are more familiar with the experience of including children diagnosed with ADHD in mainstream education and therefore are more positive towards these children. In contrast, the segregation of problematic children has been prevalent throughout recent history in Romania.

However, Scottish teachers' agreement with the fact that students diagnosed with ADHD could learn successfully in the mainstream classrooms is more complex that it might seam. Hocutt (1996) suggested, both mainstreaming and inclusion are concepts and movements, rather than precisely defined programmes. No interpretations could be generalised simply by analysing participants' responses to the self-reported questionnaire. Indeed, although the survey recommended that teachers think about the students they taught or worked with in the past, some of them might not have any experience or personal contact with children diagnosed with ADHD, their answers reflecting beliefs and opinions about the abstract concept of inclusion. Another explanation for the results obtained might be represented by the fact that the research was mainly undertaken in small rural schools in Scotland where inclusive programmes were actively implemented. The fact that the sample was drawn from one particular geographical area could impact on the generalisability of the results given the differences between school management, resources and teaching

arrangements across the country. Within this specific research context, there was an extensive support at both school (e.g. learning support assistants, special teachers) and classroom levels (e.g. availability of resources like teaching materials, IT equipment). Lack of pressure, a friendly and relaxed atmosphere, along with a supportive attitude from the headteacher represented an instrument in the creation of an inclusive ethos at school (Avramidis, Bayliss, & Burder, 2000).

The predominance of the pro-inclusion view in the current study also reflected mothers' belief in education for all, as well as increased acceptance of the Romanian education system's policy of inclusive education. In addition, these findings are likely to be a representation of the mothers' recognition that there are a number of benefits for their children if they are well supported in mainstream classrooms. However, understanding why Romanian mothers chose mainstream education was not a straightforward process.

Mothers' complex and pragmatic engagement with the models of disability offered a more useful tool for making sense of their answers. According to Runswick-Cole (2007), mothers who advocate mainstream schooling tend towards a social model conceptualisation of disability. The responses offered on the questionnaire revealed attitudes which focused more on organisational and pedagogical barriers to children's learning and not on within-child factors. As the same author pointed out, this category of mothers seemed to be sceptical towards professional assessments and expertise, being at the same time more confident in their own knowledge of the child. On the other hand, it was possible that mothers were actively engaging with different models of disability for different purposes and in different contexts. Mothers who choose mainstream do so, Connor and Ferry (2007) argued, because they are in denial about their child's level of difficulties. The idea that their

children are placed in special education might mobilise potent fears among Romanian mothers that their children are being labelled and therefore seen as defective or abnormal. As Bussing et al., (2011) also concluded, the entire process might be seen as stigmatising, a perception that could affect parent's willingness to openly communicate and report these sensitive issues in the survey.

Different contradictory views were reported by the Scottish mothers. Firstly, they believed that teachers should try classroom interventions before referring a student for diagnostic assessment. Furthermore, several mothers thought that their children should not be taught in a mainstream classroom and believed that colleagues and friends need to be protected from anyone who is diagnosed with ADHD.

Mothers' attitudes to inclusion were complex and their responses suggested that the process of inclusive education continues to be seen as fragile. Based on a bereavement model of parenting, Connor (1997) offered an analysis of parental choice of special schooling and argued that mothers' orientation towards a special school stems from their continuing sense of loss for the "normal" child they hoped to have. This sense of loss, Connor (1997) suggested, is translated into a focus on protecting the child by sending them to a special setting, rather than considering the benefit of being included in a mainstream environment. Therefore, in contrast to Romanian mothers who supported mainstream schooling, it seemed that the sample of Scottish mothers tended towards a more medical understanding of ADHD. The high value which they attributed to the professional knowledge could naturally lead to a choice of a school which offered specialist interventions and possibly cure. Based on Runsick-Cole's (2008) analysis of parents, Scottish mothers are more likely to use medicalised discourses, put the medical profession

in control, focus on barriers to their children's learning and believe in a within-child aetiology. However, it needs to be acknowledged that the choice of a special or mainstream school placement cannot be used as a simple litmus test to establish whether mothers hold medical or social model perspectives about their child. It may also be that "parents' choice of school is not only influenced by models of disability, but that parents' choice of school, in turn, constructs the model of disability with which they identify" (Runswick-Cole, 2008, p. 111).

5.2.2. *Affective attitude*

In terms of their affective attitudes, both samples of Romanian and Scottish teachers, support staff and mothers reported positive feelings of optimism and hope when it came to teaching or caring for children diagnosed with ADHD. The majority of Romanian and Scottish teachers stated that they try to convince students with ADHD that they can perform well in school. Teachers and support staff also reported that they do not feel overwhelmed by the responsibility of managing the behaviour of students with ADHD. These teachers might enter the teaching profession understanding that their work would involve teaching students with additional support needs. They might think that they need to be mentally prepared and would expect some stressful times. Moreover, a considerable number of educators indicated that they are proud of what their students with ADHD have achieved so far.

These results are surprising given the nature and frequency of the negative behaviours associated with ADHD and reported by the literature. Teachers were

consistently found to be averse to having difficult children in their classes and complained about being frustrated and stressed when teaching this category of children. The inattentive, hyperactive and impulsive behaviour of children with ADHD is known to have adverse effects on the quality of teacher-child interactions and to significantly increase the levels of teachers' anxiety, personal fear, guilt and social avoidance.

The different results of the present study might be explained by the fact that knowing a child has additional support needs would ultimately lead to tolerance and low expectations towards that person. Because of the various stereotypes and misconceptions, teachers could start believing that students diagnosed with ADHD are not capable of engaging and learning and therefore demand less of them and call on them infrequently. The low performance standards and expectations allowed the development of an apparently more relaxed atmosphere within the classroom that could make teachers' responsibilities easier to fulfill.

A preliminary analysis of mothers' responses was also conducted. Both Romanian and Scottish samples obtained high scores at the affective attitude subscale. Mothers maintained hope, struggled to ensure their child's survival and development and expressed pride, love and optimism for the future. These findings should be considered exploratory, requiring further confirmation for several reasons. Firstly, while social desirability is threatening all self-report studies, few mothers might be likely to reveal their affective patterns manifested towards their children. The severity of a child's behavioural problems might also exhibit an effect on parental reporting of hope and psychological functioning. There could be considerable variability in how mothers affectively respond to their child's disability, thus not all mothers could show the same feelings towards their children in the

same manner. However, it was beyond the aim of this study to dismiss the positive words of mothers as methodological artifacts. Despite the odds and the negative attitudes, along with the research literature that described parental reactions of anger and frustration, mothers' responses to the questionnaire showed that children diagnosed with ADHD are a source of fulfillment, pride and strength. Scottish and Romanian mothers reported that they generally managed their lives cheerfully and constructively and, although there seems to be pain, they mainly dealt with it.

These results were also interpreted by taking into consideration mothers' assumptions of pathology which influenced the way in which ADHD is theorised. Mothers who are more optimistic tend to positively reframe their child's diagnosis. Adjusting one's affective responses towards ADHD is analogous with the concept of cognitive reframing discussed by Jones and Passey (2005). For instance, mothers have initially viewed their child's ADHD diagnosis as a crisis situation caused by some neurological differences in brain development which were beyond their control. However, as Podolski and Nigg cited in Neaves (2009) explained, when mothers discover ways to help to cope with the situation, they also begin to cognitively reappraise their child's diagnosis in a positive manner. As ADHD ceases to be conceptualised as a threat, mothers start to feel less frustrated and their level of stress begins to diminish in severity.

5.2.3.*Behavioural attitude*

The statistical analysis showed that the Romanian teachers and support staff scored higher at the behavioural subscale than did their Scottish colleagues. More specifically, Romanian teachers were more willing to engage in activities and programmes in order to better meet the needs of children diagnosed with ADHD. Within the Romanian sample, support staff were more keen and hoped to undertake further training and qualifications relevant to their present post. However, the possibility of social desirability having more influence on self-reported behaviour compared with thoughts and emotions needs to be considered. A future study could reflect upon adding more convergent validity by aligning the results with other investigations that used different methods to measure the behaviour.

Despite these methodological difficulties, both samples of teachers and support staff from this study reported having little training about ADHD but more importantly educators in the Sccotish sample were not even keen to get involved in any activities aimed at enhancing their teaching competencies. A handful of studies have examined the amount of training that educators have received after finishing their formal education (e.g. Bussing et al., 2002). Teachers received little or no training (e.g. Starmont & Stebbins, 2005) and both general and special education teachers (e.g. Piccolo-Torsky, 1998) were still in need of more information about ADHD. In contrast, Reid, Maag, Vasa, & Wright (1994) found that teachers with more training had more knowledge and confidence in their own skills, found the concept of inclusion easy to deal with and expressed more favourable attitudes towards students diagnosed with ADHD. More recently, Oim (2004) found that Estonian teachers who attended courses about children with special education needs were more

knowledgeable about the identification and consequences of ADHD. This was consistent with the findings of Kleynhans (2005) who concluded that overall knowledge and attitudes towards ADHD were positively related to the number of workshops on ADHD that teachers attended.

In this context, teachers' behavioural attitudes and intentions included a lack of interest in gaining experience of and expertise about children diagnosed with ADHD. Using the construction of disability as an explanation for teachers' attitudes was once again plausible at this stage. On one hand, Scottish teachers and support staff who had an extensive background in professional development questioned their efficacy at adapting lessons and modifying activities to accommodate students diagnosed with ADHD. Furthermore, as the item analysis showed, teachers were not willing to get involved because they did not have the time to implement adequate interventions for students diagnosed with ADHD. The majority of general educators expressed concern that meeting the needs of students diagnosed with ADHD imposed additional demands on teachers' time and attention. This would conceivably lead them to approach these students as a problem to be avoided rather than a challenge that required a refinement of their skills and abilities. A completely opposite explanation might be that participants considered they had enough ability to manage these children. A person who holds a know-it-all attitude might not seek additional information and might recommend misplaced advice (DiBattista & Shepherd, cited in Sciutto, Terjesen, & Bender-Frank, 2000).

Consistent with the findings from the teachers' samples, both Romanian and Scottish mothers obtained below average scores at the behavioural attitude subscale, showing that they were not interested in gaining more experience and expertise when

dealing with their children diagnosed with ADHD. In line with the medical model of disability, mothers' receptivity and willingness to get involved in various interventions was negatively associated with their causal attributions of organicity. When mothers placed the cause of ADHD within the individual and viewed their child as responsible for their misbehaviour, they were more likely to respond negatively to such manifestations and to detach themselves from what was actually happening. According to Chronis et al., (2004), they might also give up trying to manage their children's behaviour because of beliefs that certain behaviours were beyond their control. The obvious conclusion was that mothers reached a saturation point (Arcia, Fernandez, & Jaquez, 2003) or an identity threshold (Karp & Tanarugsachock, 2000) where any strategies for improving their parental skills were considered to be worthless.

Another very important result on the behavioural attitude subscale was that the majority of Scottish teachers, support staff and parents believed that the provisions for children diagnosed with ADHD should be provided only by the medical community. These assertions might systemically influence how ADHD was conceptualised both at home and at school. Although the results at the knowledge test showed that all participants were aware of both biological and social influences on the development of ADHD, they considered that the responsibility for students diagnosed with ADHD rested only with medical professionals. This unrealistic expectation of the clinical outcome was a consequence of the belief in diagnostic legitimacy and validity. As Pearson (2009) described, teachers and parents might find themselves at the pathognomonic end of the continuum, where ADHD is assumed to be a structural, organic or neurological condition, which is internal to the students. Regardless of the degree to which participants' schemas of

ADHD were similar to the biomedical model, their responses hinged on the conviction that children's behaviour was outside the "normal" range and the children's difficulties were not amenable to instruction. The same idea was presented by Jordan and Stanovich (2003) who contended that individuals who emphasise the pathological and endogenous nature of ADHD view their responsibilities for the instruction of these students as minimal, shift the blame and act accordingly. As Arcia and Fernandez (1998) pointed out, parents and teachers perceived children's behavioural problems as residing in the child and thus possibly did not recognise the instrumental role that they might play. Conclusively, if ADHD was understood primarily as the outcome of a pathological process (Shaw, Gilliom, Ingoldsby, & Nagin, 2003), then it seemed reasonable for teachers and parents to prefer the behavioural and medical interventions, ignoring at the same time the importance of a multi-disciplinary approach.

Although a considerable number of teachers, support staff and parents from both samples showed a lack of interest in improving their skills, all participants considered the support of the child and adolescent psychiatrist and paediatrician to be the most beneficial. Considering the number of children and adolescents who are not receiving medical and psychological services, these findings reflected the hopes and beliefs in the efficacy of medical input for ADHD. However, it was difficult to determine whether the positive comments about the medical professionals simply reflected their satisfaction with the service or their reluctance to criticise their expertise. On the other hand, teachers' and parents' needs for more support from health personnel pointed to a lack of involvement of medical practitioners in the academic and social life of their patients. Although the results were at times inconsistent, they might suggest that the imposition of ADHD as a medical

diagnosis acted like a catalyst and created high levels of discrepancies between the home, school and the health sector.

Furthermore, several teachers in the Scottish sample indicated that they require additional support from other teachers and staff in the school, as well as from the family of children diagnosed with ADHD and the local authority. The same factors were identified within the Romanian sample of teachers, suggesting that, irrespective of the cultural context, teaching staff, parents and local authorities need to cooperate and develop a shared plan of action, recognising at the same time that they each face various challenges in their daily lives with children diagnosed with ADHD. On the other hand, Scottish mothers needed new ways for communicating with the school staff, parents' groups and local authorities. Again, despite teachers' lack of training related to emotional and behavioural disorders and their treatment, developing the home-school relationship was of particular importance for parents.

The extended family as a social network, the school and the church played an important role for Romanian mothers regarding help-seeking behaviours and responses to ill health. Several participants reported seeking assistance from lay and ministry counsellors and other adult spiritual figures, revealing at the same time the conceptualisation of ADHD as a spiritual problem that required religious healing and mentoring. These schemata might be rooted in both Romanian philosophy and past politics. Acorrding to Moraru (2012), a member of the Academic Network of European Disability experts, the primary cause comes from the Romanian Orthodox Church, which preaches that disability is the result of sins or weakness within the family. As 89 % of the country's

19 million population belong to the church, this has led to widespread castigation of both the disabled and their families.

Furthermore, participants from both countries did not seem to perceive the benefits of academic research in the field of ADHD. Indeed, they viewed it as research with no practical implication, research with the sole purpose of transmitting theoretical concepts and ideas with no impact upon teachers' and parents' daily experiences.

6. Interpreting the results of the semi-structured interviews

6.1. Introduction

As Arcia and Fernandez (1998) have observed, the difficulty in arriving at a consistent explanatory model of ADHD was evident in the research literature, which over the years, had multiple re-conceptualisations of the disorder. Both the content and tone of the interviews reflected the uncertainty at the heart of child and adolescent mental health practice. With so many competing claims and spins on ADHD, the confusion over how interviewees conceptualised ADHD and created meaning was understandable. Expressing different levels of emotional intensity, participants from this study offered answers along the lines of the medical model of disability which presents ADHD as an individual pathology and the social model which shifts the focus from impairment and refers to the disabling social, environmental and attitudinal barriers that prevent equal opportunities.

According to McLaughlin and Goodley (2008), using the medical discourse was necessary for parents and teachers to sort out the feeding tube of a child or to administer drugs in response to fits. However, they also engaged in processes of undermining labels, diagnoses and discourses associated with their children. Nevertheless, it is important to keep in mind that mothers' and teachers' reference to either medical or social models did not necessarily imply their adherence to the whole model. During the interviews, their conceptualisation of ADHD expanded, modified or even shifted from one perspective to another.

6.2. The medical conceptualisation of ADHD

6.2.1. ADHD as a medical phenomenon

6.2.1.1. The sample of parents of children diagnosed with ADHD

Mothers' stories about their children diagnosed with ADHD reflected a deconstructed view of the medical model where their children's difficulties were rooted in the biological difference of disability. Several Scottish and Romanian mothers described ADHD as a paediatric and psychiatric disorder. More specifically, ADHD was conceptualised as a brain disorder caused by a chemical imbalance. As one Scottish mother noted:

> There is something in the brain. It is a malfunction in the brain. His brain is not working the same as everybody else's. (Rachel-mother)

Similarly, Romanian mothers highlighted the abnormal brain development related to ADHD:

> I think in very simple words ADHD means mentally ill. I've been told this by everyone. I need to accept that ADHD is a medical condition that should be treated by a physician. (Maria-mother)

> ADHD is a disability. I don't think it is something normal. It is like a switch. When the switch goes on, it is not nice at all. When the switch goes off, I have my baby back. (Alina-mother)

On the other hand, there was a stated belief in the veracity of the heritability of ADHD. According to Parer (2010), "we inherit more than just genes from our parents" (p. 73). Although the acquired aspects of heritability are social, for mothers, both the social and the biological were framed in biogenetic terms. In this sense, by ignoring the social determinants of health, a whole family acquired the diagnosis. Insisting on the genetic inheritance, one Scottish mother commented:

> ADHD is the big bad spider with lots of legs. It is like Jekyll and Hyde. My child has ADHD and his cousin has ADHD as well. His father has ADHD although he was not diagnosed. But I am telling you, he has ADHD because I have lived with him for 16 years. My mother in law has the same problem. I can trace 4 generations of ADHD. I guess I need to thank my ex husband for this ADHD. One of my child's step sisters gave birth to a little boy. He is just 4 weeks old and he was already diagnosed with ADHD.

I think that even the dog has ADHD.

(Dorothy-mother)

The biological discourse was further emphasised by one Romanian mother:

> ADHD is definitely a disorder. ADHD is an illness. Even when I was pregnant, I just knew that something was not right. His dad was extremely hyperactive but at that time ADHD was not invented. I'm sure that he had it as well. Every symptom of ADHD is within this family. It is like a big tick in every box. (Ioana-mother)

These descriptions of ADHD were focused on the medical aspect of disability whereby children were seen as imperfect human beings. Similar to Chen's, Seipp's, & Johnston's (2008) study, some of the Scottish and Romanian mothers saw ADHD as a biologically-based disorder of a relatively chronic and pervasive nature. Their accounts made reference to the disease-like nature of ADHD and were somewhat informed by widely available, and generally agreed upon, evidence regarding the neurological and genetic nature of ADHD. As Conrad (2005) pointed out, these parents conceptualised ADHD in medical terms and often put the medical profession and its experts in control. For example, mothers from this study voiced biomedical explanations and preferred to use a clinical lexicon of disorders, conditions and illnesses. It was, however, perhaps not so surprising that in a culture where notions of health overlap with notions of normality, a condition which challenges "normal" behaviour was located within the medical domain. As Norris and Lloyd (2000) concluded, mothers are playing a part in reproducing the discourses which construct what can be understood as "normal" childhood behaviour.

Furthermore, high levels of emotional intensity were associated with mothers' evaluation of their children's symptoms which appeared to continue to negatively impact on their quality of life. They described their children's behaviour as difficult to handle and taxing, frequently leaving them feeling exhausted and overwhelmed. As the self-report questionnaire confirmed, most of the symptoms mentioned were in line with the DSM IV-TR criteria of diagnosis. As one Scottish mother affirmed:

> My child is in the big list with all the typical criteria. It is a big tick in every box. (Anne-mother)

However, for several Scottish mothers in the sample, the areas of most concern were aggression, violence and lack of concentration:

> He is easily distracted and more verbally aggressive than physical. He is crazy. He can't sit down. He is breaking things, shouting and running everywhere. He can't concentrate on anything. He wouldn't even sit and eat a meal. (Rachel-mother)

> He is very aggressive and he makes me cry. He is hyper. He is always running about shouting and screaming. He can't sit down. He can't concentrate at all. At the reading time at the nursery they had to take him away because he wasn't even able to concentrate to listen to a story. (Francis-mother)

> Once he was rolling on the floor with his head on the carpet and bum up, sliding down the stairs face first, like babies do when they are uncomfortable. Once he tried to throw a house brick at me. I had to smack his legs and grab him away. He just wasn't there. He is violent with me. But it is just his ADHD. (Linda-mother)

Romanian mothers also described issues with frequency and severity of symptoms, pointing out the high levels of hyperactivity, short temperedness and sibling rivalry:

> His behaviour can be hectic. He has his moments. If he doesn't get his own way, he becomes really aggressive. (Diana-mother)

> The boy struggles at school a lot. The teacher can't teach the class because he's too disruptive. He's so disruptive in the class, he runs around and he throws pencils at teachers. The situation is bad. It is difficult at home as well. He can't even ride a bike. He lacks concentration. Doesn't matter how much he tries, he struggles with everything. He is very aggressive with his brother who is just 3 years old. (Alina-mother)

According to Chen, Seipp, & Johnston (2008), the inattentive symptoms of ADHD reflect a distinct disorder and several studies found that hyperactive/impulsive symptoms are more frequently associated with aggression and conduct problems. Considering this, it was interesting to note that mothers made reference exactly to those inattentive, impulsive

and hyperactive behaviours that make up ADHD and have been recognised and described in the medical literature for over a century. The symptoms of ADHD were made significant by their comparison to other people. The mothers' sense that their child's hyperactivity, aggression and poor concentration made him or her intrinsically different from other children (e.g. "He can't learn as well as other kids" or "I wish he would be at least 10 % of what his sister is"') matched the view that ADHD is a unified, biological condition which reinforces the medicalised conceptualisation of the diagnosis. (e.g. APA, 1995; Barkley, 1998)

Mothers in this study also reinforced several stereotypes about ADHD, whether deliberately or unwittingly. For instance, several mothers strongly disagreed with the fact that that their children are using the diagnosis as an excuse for being lazy or naughty. In this sense, this medicalised approach assumes, according to Conrad and Poter (2000), that ADHD is a discernable biomedical abnormality that is universal and invariant to time or place. Indeed, one Scottish mother conceptualised her son as a biomedically fixed individual and stated: "ADHD is an illness. It is not an excuse for being lazy".

A considerable number of mothers reported that they trusted their clinician, being happy about the assessment and treatment they were receiving. As Pescosolido et al., (2007) ascertained, the positive interaction with members of medical staff reveals the mechanism through which mothers recognise ADHD as a health problem, contact health facilities and comply with medical advice. It seemed that the medical diagnosis could provide a powerful tool that legitimised maternal experiences and decreased the suffering. The following quote reflected the health care experiences of a Scottish mother and her judgement of the doctor's personal qualities:

> The doctor is good. He is so funny. But I don't like the nurse. The doctor is very understanding. He talks to my son and he comes across at his level. (Dorothy-mother)

More interestingly, another Scottish mother admitted that her desire to obtain the ADHD diagnosis for her child was so profound that she secured a confirmatory diagnosis through the practice of doctor shopping. As Cadwell (2007) described, parents who get involved in doctor shopping practices are parents who find it difficult to accept that their children's symptoms are within the "normal" range and therefore feel compelled to actively seek doctors who will guarantee the diagnosis label:

> We were lucky. He was diagnosed in Germany with a German doctor. The UK doctor told me that he was just a fidgety boy and he will grow out of it. When we moved to Germany, I took him to the doctor and in 10 minutes the doctor knew that he has ADHD and he was prescribed medication. (Linda-mother)

Mothers from the Romanian sample also constructed ADHD by drawing upon the medicalised discourses which placed control outside and away from children. They described how their relationship with mental health professionals developed and their willingness to follow any advice coming from the hospital:

> I didn't like the psychiatrist at first. I thought she was ignorant. I thought she wasn't listening but she was listening and she knew what she was talking about. My son really likes going to the hospital. (Cristina-mother)

> Our doctor is very good. She just understands me and my needs. She recommended us to see the clinical psychologist and I think that would be very helpful. One to one appointments always work best. (Maria-mother)

6.2.1.2. The sample of teachers and support staff

The medical conceptualisation of ADHD was also identified within the interviews conducted with Scottish and Romanian teachers and support staff. The analysis highlighted how teachers' talk made use of the "cases I know" devices which appeared against a more general maternal construction of ADHD. Using "only the cases that I know", "in a number of cases" and "some of the cases", various Scottish and Romanian teachers and support staff agreed that ADHD was due to biological causes. At this stage, it appeared that the medical model which locates the difficulties within the child was dominant. This is what Jordan and Stanovich (2003) have termed a pathognomonic perspective. According to Hoang and Dalimonte (2007), teachers at the pathognomonic (restorative) end of the continuum believe that there is a specific disease entity that exists within students diagnosed with ADHD.

Openly examining the language used along with the associated beliefs and values, several Scottish teachers and support staff considered ADHD as something to be eliminated as a blight on the gene or brain pool. Overgeneralisation, over attribution, or anchoring was common:

> As far as I know, it is all about a chemical imbalance. A certain substance is missing and it makes the body react in a different way. I imagine his brain is just working too fast. Too many things are going through his head at the same time so that he can't concentrate on what they want to do for a long period of time. (Michele-teacher)

> I think it is a medical condition within the individual. It is not bad parenting. I don't believe that anymore. I'm sure there is some bad parenting but there is also something else, possibly medical but also a genetic dysfunction from an early age. (Jennifer-teacher)

Teachers and support staff from the Romanian sample also made reference to the chronicity of ADHD, which, according to Smith (2002), renders failure into an incurable condition and fosters social policies of custody and marginalisation. Furthermore, they adopted a more categorical approach to special educational needs, using comparison with other emotional and behavioural disorders like autism spectrum disorder and dyslexia:

> I think there is something different from autism. It is a brain disorder which can be treated. When you have flu you take antibiotics to cure it. It is the same with ADHD. You need to treat it in order for your brain to function normally. (Amalia-teacher)

> I'm not a doctor. I don't know enough about ADHD and I don't want to say something stupid. I don't think ADHD is an invention made during 20 years of communism. These children existed before as well but they weren't that visible in a society that promoted intolerance. The reality is that there are a lot of children diagnosed nowadays. Some parts of the brain are overactive for certain reasons which I am not aware of. (Georgiana-teacher)

> I believe they have some form of genetic dysfunction or a neurological one. I think ADHD and dyslexia are quite similar. I would define them as conditions which require some extra help. It is not like cancer of course. No one will die from ADHD, but they need to be aware that there is something wrong there and fix it. (Simona-teacher)

In line with the medical model of disability, poor parenting and difficult familial upbringing were identified as important aspects for both samples of Scottish and Romanian teachers and support staff:

> It is nothing wrong with these kids. If you meet their parents, you'll see they are just the same as their parents. If you had tested the parents, you would probably find they had some form of ADHD as well. So I guess it is the parenting skills that are at fault not that they have the diagnosis. The way the parents are behaving towards the children is causing them to behave in that way. There is no discipline at home. It is nothing that bad and it is not the end of the world to have ADHD. People are sometimes overreacting. (Naomi-support staff)

> I am still trying to find my place at the moment. This is the first year when I've had to deal with a child diagnosed with ADHD. I can never be sure how much of the bad behaviour is due to his ADHD and how much has to do with other factors. They all have a very difficult family situation. They didn't grow up in a healthy environment. (Amalia-teacher)

Teachers and support staff also reported the negative impact that the child's problem behaviour had on their sense of competence in their role as practitioners, when attempting to deal with normal daily routines, discipline, relationships and social activities. For a significant number of teachers and support staff, the underlying belief was the

concept of an ADHD personality. Children diagnosed with ADHD were also defined in terms of embodied DSM-IV criteria that separated them from children without ADHD in the context of social living. Teachers and support staff used behavioural descriptors such as the discussion of attentional capabilities and aggressive behaviour which effectively "speaks into existence the behaviourally disordered schoolchild as a recognisable object of discourse" (Foucault, 1972, p. 50). Teachers and support staff in this study described the ADHD symptoms in a largely negative and simplistic way, focusing more on the different physical and cognitive limitations, rather than on the person itself. Overall, students diagnosed with ADHD were perceived as disruptive, aggressive, underachieving and lacking basic understanding of the things going on around them. This bias was determined by the tendency to over generalise the negative characteristics and ignore the positive information when judging children's behaviour. One explanation was offered by McCaughey and Strohmer (2005), who assessed that, if a salient feature of a child diagnosed with ADHD is regarded as negative and the context surrounding the individual is sparse, the negative view will guide teachers' perception, thoughts, and feelings about that child. The fundamental negative bias fostered negative attitudes toward ADHD mainly because the hyperactive behaviour was highly visible and regarded as socially undesirable, and the labels attached to the diagnosis of ADHD frequently carried their own negative value. More specifically, Scottish teachers and support staff perceived the challenging behaviours of their students with ADHD as non-compliant. They interpreted behavioural differences or atypical behaviours as deficit or deviance rather than as strategies of communication (Janney & Snell, 2000):

I can't really answer for other teachers. These children are just not following the standard path. The students I know can't sit still, can't pay attention, and fidget. Things like that are beyond being naughty or lacking concentration. I think everyone has some ADHD characteristics to some extent. Everyone shows some of these behaviours at times but the intensity of their symptoms makes the diagnosis itself. (Ruth-teacher)

I can only speak about the cases I know. I know this one boy with ADHD. His behaviour was just impossible to break. He was not doing what a normal child of his age would do. He disrupts the class, throwing pieces of paper everywhere, hurting the other children and running into people all the time. He wouldn't shut up. This is not right. It is not fair for the rest of the class. (Naomi-support staff)

Where to start? Usually their IQ is quite low so educationally they are at a stage below the rest. They don't like crowds. I think their memory is not that great. Giving 10 instructions, he won't remember anything because he is flustered, can't cope and he will start shouting as a coping mechanism, start throwing things and becoming aggressive. (Gillian-support staff)

The whole behaviour in the classroom is just hectic. You just can't get them to do anything. It is like they are not listening. They are deaf and blind. I noticed that hyperactivity is a big problem. I'm not sure about the lack of attention. I think the hyperactivity causes a lot of disruption in the classroom. Sometimes it is impossible to get him settle. (Sam-support staff)

Similarly, Romanian teachers and support staff constructed students diagnosed with ADHD as outsiders, and the responsibility of experts, implying that students were burdens:

> I think having ADHD feels like having your birthday every day. These children are so hyper and excited every single second. But considering that of course you can't have your birthday every day, you come to think that this behaviour happens with no reason. (Amalia-teacher)
>
> The children I have worked with were very disruptive. In other words, they were badly behaved. I can't really think of anything else. But in terms of the behaviour, it can be a nightmare. Most of them are constantly shouting, screaming, hitting, and kicking. It is like they are possessed by a supernatural power. (Alexandra-support staff)

> It is interesting that you asked me this question. I would happily invite you one day to sit in the classroom and describe the behaviour yourself. I don't have the right words to describe what is happening during one day. It is a mess. To keep it short, they are stubborn, don't follow any directions and ignore the classroom rules. (Paula-support staff)

Scottish and Romanian samples of teachers and support staff also expressed several stereotypes about children diagnosed with ADHD, the diagnosis being considered a prime opportunity for stereotype formation. For teachers and support staff, children diagnosed with ADHD behaved noticeably differently during both structured and unstructured class time in social and academic arenas. Indeed, reinforcing the medical conceptualisation of ADHD, several Scottish teachers believed that ADHD was a real disorder and not an excuse for misbehaviour or laziness:

> I don't think hyperactive children are just misbehaved children. They have a slight illness. It is like a minor disability. They just can't help themselves. It is just the way they are and what you get in the classroom is exactly how they are. (Ruth-teacher)

> I think they are more than naughty children that cannot concentrate. It should be more than that. There is no control whatsoever. It is not an excuse. It is the cruel reality for them and for me as well. (Michele-teacher)

On the other hand, one of the prevailing stereotypes for Romanian teachers was the perception that children diagnosed with ADHD were plagued with intellectual deficits that rendered them incapable of the same meaningful thought and action as their presumed competent peers. According to Tajfel (2010), these stereotypes might also partly stem from the social categorisation. Teachers tend to categorise children diagnosed with ADHD as belonging to either in-groups, where individuals are considered similar, or out-groups,

where children are treated as different. In this study, several students were pictured as probable failures, likely to be academically unsuccessful, and also as burdens: "they were strangers in a strange land who bring problems with them" (Smith, 2002, p. 97).

> I'm wondering how they can do their homework. There was this boy with ADHD. I'm always surprised by the answers he gives in the class because you always have the impression that he is in his own little world where he is not paying attention to anything. It is like his own little universe and we, the rest, are just disturbing him. (Clara-support staff)

> Children are just adults in their incipient stage. Let's be honest now. There are some very intelligent children but others are not. Not all of us are clever. Some of us will end up like you (*referring to the researcher*), in academia, but others will have to carry with their backs or get involved in illegal stuff. The education system is failing now. It is producing only manelisti[3] and princesses[4]. (Georgiana-teacher)

> I know labelling doesn't help, but the first thing you notice is the behaviour. Sometimes they seem mentally retarded. (Paula-support staff)

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[3] *Manelist is a derogatory term used to describe a certain person who likes listening to the traditional music played by gypsies.*

[4] *Princess is a pejorative term used to describe a girl with no education who is pre-occupied with how she looks.*

6.2.2. The medicalisation of behaviour

6.2.2.1. The sample of parents of children diagnosed with ADHD

Participants' accounts vividly illustrated that the landscape of medicalisation was anything but uniform. As Carpenter-Song (2009) commented, ADHD became a giant and ambiguous psychiatric net that caught a multitude of experiences and interpretations. The following quote reflected the widespread uncertainty and confusion that existed among mothers from both samples:

> I am really confused about this medication. I don't have a clue about what kind of medication my child is receiving, not to speak about what substances they contain. (Ioana-mother)

The confusion surrounding the diagnosis and treatment of ADHD determined some mothers to take extreme measures. For instance, highlighting the highly genetic nature of ADHD, one Scottish mother decided to take her son's medication:

> I really think that I have ADHD myself. I often see myself in his behaviour. You might think I'm crazy but once I decided to take his medication to see if there was any improvement in my behaviour. (Rachel-mother)

In the same way, after claiming her son was extremely restless, one Romanian mother obtained a prescription from the physician and administered her child Distonocalm[5]:

> After reading in the newspaper, I found some calming pills, Distonocalm, and I tried to medicate the child myself. It really worked. (Maria-mother)

Overall, the majority of mothers from both samples reinforced the medicalised view of ADHD. When asked about the multimodal treatment of ADHD, alternative treatments were only mentioned by two Scottish mothers but widely disregarded as being useless. Describing various dietary approaches, they acknowledged that:

> The thing with the diet is outrageous. A friend of mine, who also has a child with ADHD decided to choose the natural diet instead of medication. Her child ended up assaulting his classmates and teachers with a knife. (Anne-mother)
>
> I have also tried different diets before he was diagnosed. I was advised to try giving him fish oil. He's been taking that since he was 3 years old but I don't believe it helped in any way. It was the same with the fizzy drinks and chocolate. (Francis-mother)

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5 Distonocalm is a brand name for a mixture of drugs that is not commonly sold in English-speaking countries. It contains atropine, propanolol, amobarbital and ergotamine, being used as a treatment for migraines.

Other mothers seemed to be willing to accept the premise that medication is the only viable treatment option for their child. Parents who had an illness-oriented view of treatment accepted a medical explanation for their child's condition and believed that medication was the necessary treatment. For both Scottish and Romanian samples of mothers, medication was seen as a part of a person's identity which made children someone they are not in reality and restored the "normal" levels of functioning. Children were clearly perceived as their true selves when medicated and behaving well. The way in which medication was regarded as a way to reach an exceptional standard was reflected by one Scottish mother:

> My child is just a Vanilla ADHD[6]. He can do well even without medication but I want him to do exceptionally well. (Linda-mother)

[6] *Vanilla ADHD is a term used in the hospital environment in order to define the mild cases of ADHD.*

A Romanian mother also explained the metamorphosis that takes place when her boy is on medication, forcing her to rely upon medical professionals for support, guidance and comfort:

> When he is on his medication, look at him, this is the real him. Otherwise, you can't have a conversation with him, no control, always distracted, difficult to focus and it worries me because he is very intelligent and capable. I am always telling him: "take the tablet because it makes you the boy I want you to be and the person you should be". Even his friends are telling him: "you are a much better friend when you take your medicine". When people see him on drugs, they will never guess he has ADHD. When he's off medication, people will comment on his behaviour. (Alina-mother)

These quotes suggested that when ADHD is perceived to be a legitimate disorder, medication becomes acceptable as a treatment. It was not surprising that the mothers interviewed became socialised with the medical terminology during their hospital appointments. Indeed, it was very comforting for mothers to conceptualise ADHD as a medical condition. In this way, ADHD was reified as an internal object (Halasz & Vance, 2002), reconfigured in line with a biological narrative of behavioural causation. According to Bull and Whelan (2006), this reification precludes the wider social context as contributing to the development of ADHD. Consequently, maternal fitness was judged against the ability to give a tablet to the child, ignoring at the same time other factors that might influence the lack of control and distraction.

Another finding of this study was that the ready acceptance of ADHD as a medical diagnosis could also have positive consequences from mothers' point of view. Among the positive aspects of medicalisation, was the sense that a diagnosis could be used as a way to create acceptance, to help adults to construct a defensive mechanism and to fight the sadness and frustration. For instance, one Romanian mother reported how she fought the system in order to get her son "his right to be diagnosed with ADHD and given treatment". This narrative revealed the way in which the medical conceptualisation of ADHD empowered mothers in a practical and symbolic way. Furthermore, according to Kendall (1998), once parents have accepted that their children are different, they gained emotional acceptance of the difference. The diagnosis might confer power, relief and a collective identity, removing mothers from isolation and providing them with new potential networks of support.

For other mothers, academic achievement acted as a barometer indicating the need to receive treatment and support. These respondents indicated that, without medication, their children were less able to function adequately and often unable to do things they believed they could do. Great concern for, and over-emphasis on, academic achievement were fueled by the medical model which emphasised the individual's incapacity to reach certain standards. As Schermer et al., (2000) ascertained, medicalisation is now focused more and more on enhancing suboptimal performance in a society in which the social norms for performance are getting higher and the socially acceptable range of variation in performance is getting smaller. For instance, one Scottish and one Romanian mother believed that the ADHD diagnosis and the need for medication stems from a perception of under or over performance:

> He is in an open class school, in a low ability group. He is underachieving at school and he doesn't really receive any support from teachers. He needs medication. He needs to take pills. (Dorothy-mother)

> He is doing great at school. He never has problems with teachers, although they weren't that tolerant towards my daughter. He is above average in maths, he is a clever boy and his grades were always one of the highest. I don't see the point of medicating him. (Maria-mother)

Mothers' talk about children's medication reinforced the fact that ADHD was still a highly medicalised phenomenon in both cultural settings. The willingness to identify problem children and to press for medical treatment made the parents' jobs easier and cemented their role in the ADHD medical diagnostic apparatus. As Singh (2002) commented, these narratives "veiled the medical profession's long romance with ADHD and medication as a tool to manage the relationship between mothers and sons" (p. 599).

6.2.2.2. The sample of teachers and support staff

Teachers and support staff also adhered to beliefs about ADHD which led them to accept or reject the need for treatment. For instance, teachers and support staff who perceived ADHD to be a valid medical condition also had positive views about the psychotropic interventions to manage the inappropriate behaviours displayed by students within mainstream classrooms. With regards to some of the teachers and support staff from both Scotland and Romania, there was a clear orientation to the ADHD repertoire as a medical explanation for children's difficulties and as defined by diagnosis and treatment. This biological repertoire was at times influenced by the way in which ADHD was represented and debated in mass-media. As Schünemann (2009) ascertained, the media are able to construct a skewed reality of ADHD because of their public and institutionalised position in society where reality is continuously and socially being constructed. Indeed, for one Scottish practitioner, the mass media was considered as the culprit in the formation and maintenance of her attitudes towards ADHD treatment:

> Again it was this programme on the radio. A family with a young boy chose Ritalin and they were not very happy but they saw an enormous change in his behaviour and home life. So definitely it suited them. In the case of my student, when he was on medication, at some point his behaviour did seem better. (Sam-support staff)

In the same way, drawing on the socially constructed information provided by a local newspaper, one Romanian teacher acknowledged that ADHD is a scientifically valid disease which can be cured by an adequate medical intervention:

> I heard a lot of things about Ritalin to start off with. You know the recent newspaper stuff about these drugs but from my experience, the children I have worked with, they did quite well with it. It is as simple as that: children that react well to the treatment will continue to take it, and those that don't, they will stop it. (Simona-teacher)

Uncritically accepting the medical model, some teachers and support staff believed that there is no known cure for ADHD, and therefore became dependent on early diagnosis and ongoing expert intervention to reduce its lifelong effects. On the other hand, both samples of Scottish and Romanian teachers made reference to the behavioural normalisation with methylphenidate. In an age of perfect students, medication provided a vocabulary to explain the meaning of children's manifestations and of their own abilities. In other words, the very personhood of the child was often reconstructed by administering a pill that can "seriously threaten a way of living that is uniquely our own and not that of someone else; that it threatens to separate us from who we really are and how the world really is " (Elliott, cited in Bolt & Schermer, 2009, p. 109).

More specifically, the societal pressure to conform to an ideal was highlighted by one Scottish primary school teacher:

> I don't think teachers can cure ADHD as it is expected. We have to stop blaming ourselves for not being able to control these children. Can they be cured anyway?! Many kids truly needed it *(referring to medication).* They could not function properly in school, despite our best efforts. If you've ever been around a kid with a valid diagnosis of ADHD, you will understand it is not just normal kids being kids stuff. (Jennifer-teacher)

As a proponent of the medical model of disability, another Romanian support staff also believed that psychopharmacological substances could help children get better and therefore strengthen their identity and authenticity:

> I am thinking about this boy in P 3. One day he set off the fire alarm, he brought a knife into school and he threatened his colleagues with a syringe. You get to a point where nothing else is working. You try everything as a teacher. Medication is the only way to calm him down. I have seen how he changed. He just got better and better. He is almost like a completely new boy. (Paula-support staff)

In the same manner, for several Scottish teachers and support staff in the sample, medication was also accepted and promoted because of its beneficial effects on classroom behaviour and enhanced academic achievement:

> You have to look at it like that. He wouldn't be seeing the paeditrician if he *(referring to a particular child)* didn't need the medication. For some children there is really no other way. I know when a child didn't take the medication in the morning. You can tell when a child is simply having a bad day, and a child that did not take the medication. There must be a biological explanation because I've never seen a child being given Ritalin because they didn't do what the teacher expected of him. (Naomi-support staff)

In line with the medical model of disability, the side effects of medication as an intervention were largely ignored by some of the Romanian teachers and support staff. They often assumed that the side effects were a normal part of taking medications and minimised their importance by comparing the ADHD treatment with other simple pain relievers:

> Sometimes it works like that. If you have a headache you take a Nurofen and the pain goes away. It is the same with ADHD. You might need to take a tablet to be able to concentrate. There is nothing bad or stigmatising about that. (Clara-support staff)

6.2.3. Behaviour is out of control

6.2.3.1. The sample of parents of children diagnosed with ADHD

Participants' narratives reflected debates in the literature, with different views being expressed as to the extent to which the behaviours are within the control of the child, or are the product of biological or social influences. For example, several Scottish and Romanian mothers attributed their children's difficulties to the fact that they had an attention deficit, a medical problem for which they are not responsible. By adopting the medical disorder perspective, mothers viewed children's behaviour as out of their control. Their description of children's symptomatology indicated that children's behaviour was conceptualised as being a relatively non-intentional mental state that reflected the disorder rather than the child's characteristics. This underlying belief showed up most clearly in the types of explanations that Scottish mothers found for their children's problems:

> I know he is not an angel and I don't try to make excuses for anything. But he usually likes to fight back when he's not treated well. For example, he was accused once of breaking a friend's earring. But he didn't do anything. It is never his fault. (Anne-mother)

> People say he is not that violent. I'm glad. But he is very violent towards me. It is just his ADHD. (Francis-mother)

Describing teachers' attitudes towards their children, Romanian mothers also echoed their understanding of ADHD:

> Teachers need to know that it is not always his fault. They are saying that just because he has ADHD. Teachers only see him hitting back. But what did they do to him before that? I wish I had never put him in that school. Once I was called in for a meeting because he told one of the teachers some bad words but what happened was that someone was calling him names in the classroom, and he was the one being punished by not being allowed to have a break for a week. (Diana-mother)

> Teachers have to give back respect, especially to a child with ADHD. They say this is bad behaviour, but he goes to the teacher and complains that someone punched him, annoyed him etc, and the teacher says: "go away, stop making a fuss about it, what did you do to deserve that?" (Cristina-mother)

The participants' emotional arousal was also influenced by the belief that children were not able to exert any type of self-control of their behaviour including the regulation of the symptoms of ADHD. For instance, mothers in this study displayed an overwhelming reaction of no hope determined by their essentially individualistic understanding of ADHD as an unfortunate event resulting in many unwanted symptoms. Their language was embodied, emotional and contextualised. Words like "nightmare", "horrible", "isolating",

"disoriented", "exhausting" or "breakdown" portrayed mothers' feelings of anger, hurt and sadness. In this context, the medical conceptualisation of ADHD was reinforced by both samples of Scottish and Romanian mothers:

> This is a living nightmare. Will I ever go out of this? Every single day is the same. You just feel like you don't want to do anything. When is this ever going to end? It is always the same, never different. (Linda-mother)

> I am very scared for his future. I am terrified. Children smoke, have girlfriends, how can I protect him? (Dorothy-mother)

> I am worried that he will end up like his brother (no job, no future). He does try. It is heart breaking because no one gives him a chance. (Diana-mother)

One Romanian mother believed that their child was affected by something that she did not understand and was powerless to control. By looking for guidance from a divine source, these distortions determined a heightening of maternal stress and anxiety:

> Knowing that my child has ADHD increased my spirituality. Now I go to the church and pray. That makes me more hopeful and optimistic. I will advise everyone to turn to God. (Maria-mother)

In this context, ADHD could have a huge effect on a mothers' emotional state. According to Kendall (1998), these mothers seemed to be caught in a circular pattern of negative experiences. They got stuck, gave up, burned out and finally they got stuck again. To a major degree, their behaviour derived from the feelings about having a child diagnosed with ADHD. "It is vicious circle; you can't do more as a parent, it is only so far that you can go", one Scottish mother commented. It was therefore not surprising that, for example, Scottish mothers came to the full realisation that no matter how hard they worked with their children and used the techniques they were taught, the situation would not get any better. As a consequence, they seemed to reject any form of support and took a negative view on what value additional training might add. The burden of responsibility for the problem was shifted again off the system and onto the individual. Touching back on the medical model, mothers' narratives reflected the belief that children's educational and personal difficulties were once again the result of an irremediable defect. By attributing the behaviour to internal, uncontrollable and stable factors, children become disempowered and had no responsibility for their actions. Describing their experiences after attending various training programmes and support networks, two Scottish mothers commented:

> I am sick to death of talking about ADHD. It is just try this, try that. I don't like speaking with people because they are older, they don't make me feel comfortable and they don't have a child with ADHD. They studied a lot but not only about ADHD so they wouldn't know. I always tell them: "you come and stay in my house and then tell me to try something else". You get sick of trying and hearing your own voice. (Linda-mother)

> It was a waste of time and I did not achieve anything. It can get tiring as well because all parents think their kid is the worst. There is too much negativity. (Anne-mother)

Furthermore, a closer look at the interview transcripts showed that although several Scottish and Romanian mothers were supportive of mainstream education for their children, they were often overjustifying or minimising negative behaviours. From their point of view, children diagnosed with ADHD could be included in mainstream but they are unable to function normally and to carry out everyday activities. In line with the medical model of disability, some mothers perceived their children as lacking control over their behaviour, incapable and unable to think or voice an opinion. For instance, one Scottish mother stated that her child could not function independently at the most basic skill levels:

> Yeah, he seems to be ok in mainstream. He is doing all the bad things because he wants to be popular and accepted. He had no problems with bullying or being excluded because I taught him that if someone hits you, you hit him back. His condition is never mentioned as school but he has to be told exactly what to do and how to do it. (Rachel-mother)

Similarly, the need for constant guidance and correction was mentioned by one Romanian mother:

> I agree with mainstream but he needs additional help in class. He needs help to focus. He doesn't like text books. He needs simplified versions and less technical explanations. He needs concrete examples. He needs to know why and how it works in real life. (Alina-mother)

6.2.3.2. The sample of teachers and support staff

In this study, for many teachers and support staff, children diagnosed with ADHD were described as not responsible or punishable for their actions. According to Gray (2002), not only did the children not have to take responsibility since "it was not them it was their syndrome" but teachers also positioned themselves as powerless to enforce discipline. By accepting that the child had little or no control over their actions, teachers and support staff became positioned as non-experts when faced with this medical condition. Furthermore, in describing the effects of medication, teachers also implied that the tablets had a controlling effect. However, what was more significant for Scottish teachers was the apparent belief that children diagnosed with ADHD were not "normal" because they had genuine and enduring difficulties which were beyond their control:

> They just cannot help themselves. They cannot control it. I found it hard to give them punishments because I thought *"oh it's not his fault"*. I shouldn't punish them for something they cannot help. Sometimes I believe that once children get the diagnosis, somehow I stop feeling responsible for their behaviour and I think that the doctors are in charge. (Gillian-support staff)

> *"I can't help it, I've got"*. But to be honest, they can use their ADHD as an excuse and we can use their ADHD as an excuse as well. If we don't see any results, we just think: *"well he has ADHD and we've tried everything"*. (Sam-support staff)

Several Romanian practitioners were also on the side of the medical model which asserted a lack in the faculty for control. The overall view was that students were not entirely responsible for their actions:

> Imagine that someone is following you and you have to run but someone else is controlling your legs all the time, slowing you down or speeding you up. It must be really frustrating for these children because they're not in control of anything. (Paula-support staff)

> In terms of the behaviour, it can be a nightmare. It is like they are possessed by a supernatural power. (Georgiana-teacher)

Teachers' and support staff's emotions were consistent with the medical model previously discussed whereby the child was viewed as lacking control and ADHD was a treatable disorder. Educators adopted the medical discourse around ADHD which increased their negative expectations about the severity of the child's problems, elicited more negative emotions, and decreased their confidence in their ability to instruct the child. Teachers and support staff described shared emotions including exhaustion, sense of failure, worry, disappointment, helplessness and irritation. Furthermore, many teachers and support staff from both samples reported being significantly more stressed, upset and struggling to cope with an underachieving and misbehaving child. Indeed, pupils diagnosed with ADHD were seen as causing concern for most of the Scottish teachers and support staff:

> It is a lot of stress because you are dealing with students with serious problems and sometimes you feel like you are not prepared for that. I find it hard to cope to a certain extent with a child being so disruptive. And you also feel the pressure from the parents. You are constantly under pressure. (Ruth-teacher)

> I'm really disappointed because of one child in particular. I couldn't make any sort of connection. There was never a real closeness between me and him and this is really upsetting for me. It was like he didn't like me or hated me that much that he wouldn't listen to anything I was saying. You start feeling guilty because you can't reach those students no matter how hard you try. (Naomi-support staff)

More importantly, this constellation of negative feelings along with the challenges associated with ADHD determined one Scottish teacher to lose confidence in any sort of specialised support that she might receive. She found herself on a downward spiral towards chaos and accepted the situation as unchangeable:

> When you've got a kid with ADHD in your class, waiting for him to get the diagnosis can feel like an eternity. I haven't got the training required and life is very busy to keep going on these training courses. Imagine how it would be if I were to attend a course on every single disorder I have encountered in my career like ADHD, Dyslexia or Asperger's syndrome. I have so many different kids in my class and it is impossible to choose only one type of need to focus on. (Jennifer-teacher)

Conceptualising ADHD as a super power that controlled children's personalities, several Romanian teachers and support staff were less confident in their teaching abilities and described intense, emotional battles when encountering children diagnosed with this condition:

> Sometimes you feel like giving up. Everyone is expecting you to manage behaviour in the class, write reports, medical letters and to undertake training. Sometimes it feels just too much. (Amalia-teacher)

> Think about teaching a class with 40 children. It can be overwhelming if you don't have experience in dealing with challenging behaviour. Even if no one is willing to admit, it does take a lot of time to deal with a child with ADHD and of course you think about the rest of the class who is left behind and ignored. (Paula-support staff)

6.2.4. The "specialness" of ADHD

6.2.4.1. The sample of parents of children diagnosed with ADHD

The majority of Scottish and Romanian participants believed that children diagnosed with ADHD should be taught in mainstream classrooms but their educational needs should be addressed differently from what they called "normal" children. Several mothers in this study resisted messages of normality and conceptualised ADHD as a disability which did not allow children to become the desired "normal" child. By thinking that their children should be eligible to receive special benefits, mothers approached ADHD as a personal tragedy, an unfortunate individual circumstance that required professional assistance. According to Clough and Barton, cited in Goodley (2007), children were marginalised through their construction as an othered group requiring empowerment. The medical model was used again to give this difference an authoritative and legitimate standing. Seeing themselves as experts of abnormality (Parer, 2010), their insistence on difference could represent a force against inclusion.

Overall, Scottish mothers strongly believed that, in order to teach a child diagnosed with ADHD, educators need to make use of a completely new set of techniques specially designed to alleviate the nightmare:

> Yeah, I think he should have the right to mainstream education. But let me tell you something. He is different and he requires special attention from everyone. I had to go to school and explain to the teacher that he can't be asked to sit at the end of the classroom. (Anne-mother)

> I understand that schools don't have the funding for extra support but I don't want him to end up stupid because of that. I've offered to stay with him for a few hours per day in the classroom, but the school said no. See, I am trying my best. (Rachel-mother)

Romanian mothers also believed that, if they are to be included, children with ADHD require adapted education and flexible arrangements:

> He needs his own support worker but due to allocation and funds, he doesn't have one. They only have a classroom assistant for 30 minutes per day. This is not enough. (Ioana-mother)

> I strongly think he needs special support and I also think teachers treat him differently because he has ADHD. (Diana-mother)

By emphasising the differences between a "normal" child and one diagnosed with ADHD, Romanian mothers portrayed the problems that their children might have in mainstream. One mother believed that positive exposure to the so-called "normal" children would only promote acceptance and tolerance:

> We had to change several schools but in this last one I have an exceptional relationship with the staff because I was honest from the beginning and I explained the problems that my boy has. Being with normal children is great. He made a lot of friends and he became really independent. Maybe a smaller class will make even a bigger difference but you can never have it all. (Cristina-mother)

Similarly, several Scottish mothers had serious reservations about inclusion in mainstream schools and tended to be hesitant and sceptical when faced with decisions about their child's education. By mentioning the necessity of the special treatment, participants identified themselves with the medical model of disability and treated the child as the source of deficiencies. Normalising disciplines created the awareness of impairment as "a deficit of corporeal integrity and simultaneously as an invalid social position" (Hughes, 2007, p. 683).

While education was perceived as a form of treatment (Jordan, 2008), ADHD became a site for intervention and provided a vocabulary from which mothers could teach the schools how to look after their children (Kendall, 1998):

> My son is in mainstream. However, I don't know if this is the best option. Teachers are always complaining that they can't teach the class because he's too disruptive. They made him stay on his own while everyone else sits with someone. Usually there are 5 kids at one big table but he stays alone. They say this is the only way they can make him behave. (Francis-mother)

> The school situation is very bad. He is very aggressive and confrontational. Last year we had to move him into another school with fewer children in the classroom. So yeah, he is in mainstream but teachers are giving him a hard time. He got punished by the teacher just for saying the word "stupid". He was made to sit at the back of the class and his golden time taken away. Sometimes I wonder if he would be better off within a special education school with more support staff. (Linda-mother)

> He is in an open class school, in a low ability group. He is underachieving at school and he doesn't really receive any support from teachers. I don't even know what to do anymore. Maybe the solution is to take him out of school education and go for home schooling. It is a vicious circle. You can't do any more as a parent, and it is only so far that you can go. (Dorothy-mother)

Mothers from both countries seemed to identify their children with the ADHD diagnosis and they believed that the diagnosis should give access to assistance. As one Romanian mother described, too much support could actually be discriminatory and stigmatising:

> Sometimes too much support and special attention prevents my child from interacting with his peers and it makes him look weird in front of his pals. He is sometimes embarrassed by the fact that he always needs to receive special treatment from the school staff. (Ioana-mother)

As mentioned before, for many mothers, educating their children demanded a whole set of advocacy issues, which arose out of necessity. According to Peters and Jackson (2008), mothers had to advocate strongly, ensuring that their children's special needs were considered. For both groups, shared understandings and spreading information about ADHD was important. Empowered by the diagnosis, mothers stood up and confronted the teachers. They wrote complaints and admitted that probably some teachers got scared by their attitude:

> I have even put together a leaflet with information about ADHD and I took it to the school. I don't think anyone read that. It probably ended up in the bin. (Anne-mother)

> I went to a school meeting with my mum. She had a degree in child care but I didn't mention anything about that to the teachers. They were very confrontational: "your child comes to our school, he's causing problems and we don't want him here". Other parents will be scared but I stood up and showed them the CVs of me and my mum. Their attitude started to change. This is so wrong. I shouldn't have to prove that I'm an educated person for them to listen to me. What about the people who are not as lucky as me? Their education is suffering. (Diana-mother)

While the data shows a huge communication break-down between teachers and parents, what was interesting was the parents' belief that advocating for their children would raise awareness of ADHD, and break down stigma and stereotypes. Many of them described how they had to fight for the needed resources and how they had to fight to educate teachers. However, it might be the case that, rather than eliminating the diagnosis stigma, by distributing leaflets about the specialness of ADHD, parents emphasised the shortcomings of their children and promoted an expansive view of difference. As the Children's Society in Wales, cited in Webb (2002), highlighted, "advocacy is not about saying what's best for a child but about enabling that child or young person to come to informed decisions about matters which are affecting their lives".

6.2.4.2. The sample of teachers and support staff

Similar results were obtained when analysing teachers' and support staff's transcripts. Children diagnosed with ADHD were often perceived as being different, not "normal" and permanently in need of special accommodation and adjustments. Overall, when describing their experiences, teachers regarded factors within education as the only barriers to learning and development, mentioning issues relating to the placement of children with ADHD in special schools, the necessity of specialised professionals and training, the benefits of special units within the mainstream and the use of different teaching strategies. In this context, as Avramidis, Bayliss & Burder (2000) pointed out, teachers and support staff were actually more assimilated into an integrationist model, in the sense that they were over-stressing the need for special provision in order to accommodate and teach students diagnosed with ADHD. In a period in which resources and general funding are monopolising the discussion about inclusion, several teachers and support staff from this study ignored the fact that inclusion is mainly centered on values. According to the same author, if teachers conceptualised the problem in terms of skills deficits and specialness, rather than social and ethical requirements, children diagnosed with ADHD will always be marginalised and deemed uneducable.

Scottish teachers' comments reflected the ongoing debate regarding inclusion and the sense of frustration and challenges that children diagnosed with ADHD presented in regular classrooms:

> It depends on the individual child. If it is severe ADHD, maybe a special setting with more support and extra funding could be more beneficial. For mild cases you can try understanding the condition and listen to the parents. If they can afford it, parents might choose a private school that specialises in children with different types of learning disabilities. (Michele-teacher)

> It is hard to say if inclusion works. Before coming to my school this boy with ADHD was enrolled in special education and he was doing far better than in mainstream. Here, he had a very negative effect on his peers and this filtered through the school. Everyone knew him and people were complaining he did this and that. (Sam-support staff)

Other Scottish support staff considered that the inclusion of students diagnosed with ADHD would negatively affect the teaching-learning environment. Similar opinions were expressed by educators from Hodge et al.'s, (2009) study, who found that the more inattentive, hyperactive or behaviourally disruptive the student, the more time is needed to prepare classes, and the more difficult it is to plan and organise these classes.

In this sense, one Scottish teacher acknowledged that inclusive practice was simply more difficult:

> Yes, as with most mental disorders there are varying degrees of severity. It really depends on the child. You cannot say one size fits all. As someone who works with challenging behaviour, I believe mainstream can work but it takes time and effort. Or it is possible for children to attend some special lessons in the morning and then come back into mainstream in the afternoon. (Ruth-teacher)

In the Romanian sample, teachers and support staff expressed similar views and perspectives. For instance, one Romanian teacher explained how her attempt to normalise ADHD failed and ultimately she was forced to accept back into her classroom a student who did not fit into the ideal norm:

> I think it is very hard to transform a child with ADHD into a normal child. I will give you just one example. There was this little boy diagnosed with ADHD, extremely hyperactive and lacking attention span. He had big conduct problems and was aggressive towards everyone. The parents of the other children in the class asked me several times to take him out. They actually begged me. I spoke with the head teacher and we decided to transfer

him to another school on disciplinary reasons. Everyone was happy except his mum. She made such a big scandal. She came all shouting and screaming. She complained to the school inspectorate so we didn't have any other choice other than allowing him to come back to school. Do you think this solved anything? He needs psychological counselling and we don't have the possibility to provide this (Simona-teacher)

Starting from the assumption that children cannot be taught in mainstream, one Romanian practitioner decided to create a special environment for children diagnosed with ADHD:

I have recently opened an after school club to help parents who have difficulties with children with ADHD. It is a place where I can spend more quality time with the students with ADHD from my class, more one to one time. I thought that if the mainstream is not helping students with ADHD and not doing anything to correct them, something had to be done. I have also worked in a day centre where these children were taught by teachers with experience in special needs. The programme was free of charge and was offered by the General Direction of Social Assistance and Child Protection. (Paula-support staff)

As Smith (2002) observed, misperception of students' engagement and understanding also accompanied the attitude of many Scottish and Romanian general education teachers who believed that it was up to the special education teacher to educate children diagnosed with ADHD. Expert teachers were viewed as a necessity. Other teachers were more concerned with the training they received for catering for the so-called "normal" learners. Quality of professional preparation was also viewed as a variable that either hindered or facilitated the ability to teach students with disabilities. In both cultural settings, teachers adopted a deficit-based perspective where their focus was on the lack of specialised staff, training and equipment:

> I think students with ADHD can be included as long as they are medicated adequately. I have no support as my school just doesn't have the money to pay the staff. I am always trying to find the best ways to reach them but I don't have the training for special educational needs, and I really think I need it for this class. There is barely any time for one on one, which is what these children desperately need. (Naomi-support staff)
>
> It is very hard to integrate children with ADHD in mainstream. If you are a primary school teacher and you have children with ADHD in your class, you need to ask for a support teacher. At the start of each academic year, you need to take part in a multidisciplinary meeting together with an accredited psychologist, speech and language therapist and one social worker. However, there is no guarantee that a support worker will be allocated to your class because there are very few support workers in the city. (Amalia-teacher)

> We cannot speak about inclusive schools in Romania. It is more like a physical integration rather than a real one. In mainstream, there is no support for children, families, staff and teachers. It is a segregationist approach towards ADHD. Honestly, I don't like working with these children because it is a waste of time. If you work with gifted students you can achieve more benefits. (Clara-support staff)

Nevertheless, in the construction of teachers' talk, the tendency to make special allowances was apparent. What was clear from these extracts was how generic teaching strategies were minimalised in favour of medically adapted teaching strategies which were often dependent upon the ADHD diagnosis. In line with the medical conceptualisation, teachers and support staff made efforts to normalise by adopting special teaching techniques. Indeed, several educators from the Sccotis sample spoke of a need for adjusting instructions, climate control, planned ignoring, adapting lessons, or modifying activities for students diagnosed with ADHD:

> What strategies do I use? Sometimes I ignore children with ADHD and deal with them outside teaching hours. I maintain the structure to the lesson because they respond well when everything is nicely organised and they know what, how and when they need to do something. I use rewards and sanctions as well. Sometimes giving them some time out it is the only way I can go on with my lesson in the class. It is hard to be calm when they are so disruptive. (Michele-support staff)

> You need to find the right level for them. It is back to basics. We have an additional support needs teacher who comes once per week but it is not enough. Then there are 4 other support for learning assistants including me but I don't think this is enough either. Sometimes they need more support and more time with them. 30 minutes is not long enough for a child with ADHD. Working in groups is not great for children with ADHD and the Curriculum for Excellence is promoting this. (Sam-support staff)

Similarly, describing the required environmental control, one Romanian teacher believed that in order to provide a good education, a series of strategies were necessary:

> I have a lot of children diagnosed with ADHD in my class. It is so hard to keep up with their speed. Theoretically speaking it is easy but the reality is completely different. How can you make the other kids in the class keep up with the ADHD speed? It is very hard to teach everyone in the same way. (Simona-teacher)

6.3. The social conceptualisation of ADHD

6.3.1. ADHD as a social phenomenon

6.3.1.1. The sample of parents of children diagnosed with ADHD

Meanings about the concept of ADHD were socially constructed by both the Scottish and Romanian mothers who also brought vividly to the fore the limitations of the medicalised approach. Several participants from this study displayed concerns regarding ADHD as a medical diagnosis and avoided dealing with the definitive concept of disorder. Their stories were more in line with the social model of disability whereby the focus was not so much on the medical aspect of ADHD but on the role of the society and in particular the medical system and the schools. Firstly, Scottish and Romanian mothers epitomised the active questioning of, and scepticism towards ADHD but on completely different bases. For instance, several mothers in the Scottish sample believed that ADHD was mistakenly identified with some sleep problems experienced by their children:

> ADHD is not a disorder. I think ADHD has something to do with his lack of sleep during the night. My child goes to bed around 1 in the morning, with the lights on and a DVD with cartoons playing the Simpsons. (Rachel-mother)

> He is just a normal boy. I don't even believe my son has ADHD. We were literally dragged into the system. We initially came for some sleep problems. Then we got diagnosed and we have to come every so often. It is like a circle which you cannot escape. Once you are in the system there is no way out, at least for the moment. (Anne-mother)

For the mothers in the Romanian sample, teachers' negative comments appeared to have been the catalyst for their decision to seek a clinical diagnosis. The notion of meeting the demands of institutions, in particular, schools, seemed to determine the necessity of finding an explanation for the children's inability to cope effectively with a day in the classroom. A few Romanian mothers found it difficult to accept the teacher's assessment of their children:

> My main concern was the school. I just got so sick of teachers complaining all the time. You know, if you are not a perfect well behaved student, you're considered ill. Something is wrong with him. He needs to be tested for ADHD. Teachers are always saying what you can't do. You can't do this, you can't do that. It's not like I'm denying the reality. I am just saying that maybe the diagnosis was made too quickly for my son. Maybe he is just a happy boy, a bit more active than the others. (Maria-mother)

> Maybe it is just a mild condition, a small problem, nothing major anyway. I have always put it down to the fact that he was just being a boy but teachers considered he has ADHD. He hasn't had any medicine this morning and he looks just fine. (Diana-mother)

Resisting the medicalisation of behaviour, both Scottish and Romanian families used a more diffuse vocabulary of a "mild condition", "issues", a "small problem" and "being normal" to describe their children's symptoms. The ADHD symptomatology was described in more positive terms. For instance, one Romanian mother emphasised the uniqueness of her son and the variety of ways in which ADHD could be understood as an advantage and not as an illness. By arguing that ADHD was something special, she adopted a discourse that celebrates difference. The pessimistic portrayal of ADHD was abandoned in favour of a more positive attitude and perseverance:

> He is doing great at school. He is above average in maths, he has problems with writing but he is very good at computers. He is extremely intelligent. That is his advantage. His behaviour is so good because I spend a lot of time with him, doing the homework and establishing routines and rules. I have also spoken with all the teachers and explained to them why my son is special and how they have to treat him in school. (Diana-mother)

Because the very meaning of being diagnosed varies across time and space, ADHD cannot be reduced to a mere biological problem located in an individual's body. Indeed, both samples of mothers denied the biologically-based approach and associated the child's symptoms more with the cultural and social interactions that take place within the family or school:

> Sometimes he is lazy. He doesn't like this, doesn't know how to do that and it is affecting his school work. And what he does in school affects him. (Linda-mother)

> Sometimes I think he is just spoiled and lazy. Maybe it is my fault. Maybe I have offered him too much or, I don't know. I guess it's a bit of everything. (Cristina-mother)

The diagnosis created more room for understanding and acceptance of problems, so some mothers chose to focus instead on children's strengths. Contrary to the medical model of disability, several mothers in this study did reap some rewards from parenting this category of children. For several mothers in the Scottish sample, children diagnosed with ADHD were a source of joy, love, pride and fulfillment:

> Sometimes I feel sad but I'm really proud of my boy. I know he can do well and I'm going to fight for him. People need to understand that he is just different. (Francis-mother)

> He is very intelligent. I love my baby more than anything in the world, but sometimes I really hate his behaviour and I struggle to see past that. (Anne-mother)

> I just know that I will always be there for my son. I will be behind him no matter what. If I am not going to help him, who else can do it? (Dorothy-mother)

Positive parenting and focusing on the bright side of ADHD was also of great importance for mothers in the Romanian sample:

> You have to be very firm as a parent but fair at the same time. It is really hard, but not impossible. It is just a matter of wanting your child to do better. I think this experience made me a better person and it strengthened me. The little things that my baby does makes me so happy. I really admire him for trying so hard all the time. A little bit is better than nothing. Parents need to focus on what the child can do and I am a million times happier because he's done it, because he wasn't supposed to be able to do it. This is my child and I can't change him so I need to find different ways of dealing with his problem. I just try to look at the positive side. (Alina-mother)

> I have always tried to do the best for my child. He taught me how to be more compassionate, less selfish and more tolerant. It is like my whole perspective on life has changed. What is important in life is clearer now. I have also learned to make the most of each day, living life at a slower pace. He has to live his life and I can only give support and guidance, as a loving parent to my child. I can hopefully guide him in the right way, set the example and just go with it and see what happens. (Maria-mother)

Some mothers described the ADHD symptoms through teachers' eyes. As Johnston and Freeman (1997) also observed, parents tend to see positive child behaviours as more dispositional and negative behaviours as more attributable to situational factors. Mothers' descriptions emphasised the social contexts within which their sons' behaviours were manifested. The following quotes suggested that almost regardless of the actual nature of ADHD, the social context was of enormous importance for both samples of Scottish and Romanian mothers:

> He is my second child with ADHD and I had an awful lot of bother with school. My older son left school with no qualifications. I don't want him to end up in the same way. (Francis-mother)

> At school he is swearing at teachers and at home he is a nightmare. He was doing great when he started school, doing his homework alone and so on, but since he was diagnosed with ADHD everything changed. (Maria-mother)

Another theme that emerged was related to mothers' stories about their children expressing the wish to kill themselves several times. For one Scottish mother, these tendencies were caused by a long-term frustration associated with a lack of social interactions, social intuition and comfort:

> He tried to kill himself once. He told me that if I was his mum I will help him get out of this world because he hates it: *"if you love me that much you will get me out of here"*. I think this is happening because he doesn't have many pals. He can stay in the house for days without seeing anybody. He runs and hides when someone is ringing or knocking the door. (Linda-mother)

The same idea was underlined by several Romanian mothers who were very frightened and worried about the consequences of their children's behaviour. They first set the scene by exploring the harmful and antisocial behaviours in which children engaged and their particular experiences when dealing with the police:

He can start cutting himself or threaten that he is going to kill himself. He doesn't have many friends. He met some other children with ADHD once, but they didn't get along very well. (Alina-mother)

He also had problems with the police. He got arrested because they found him intoxicated and drunk. I think he had too much vodka. We used to get drunk as well when we were young, but not really that young. He was then arrested for attempting to assault a police officer. (Diana-mother)

He had lots of problems with the police for breaking some car's windows and setting an abandoned house on fire with another boy. However, he just got off with a warning. He started stealing from home and school (*referring to a school camera*). He eats like a horse and steals like a pig. (Cristina-mother)

6.3.1.2. The sample of teachers and support staff

Constructions which provided alternative explanations for children's difficulties were offered by several Scottish and Romanian teachers and support staff. In line with the social model of disability, they preferred social environmental explanations as opposed to the epidemiological evidence as a cause of ADHD. For instance, for two Scottish teachers, the "not ADHD" repertoire achieved dominance in relation to the ADHD narrative:

> ADHD is fairly new to me. I have just starting teaching and I don't have much experience with these children. I have only now started working with two students with this diagnosis but I think they are just wonderful little children. They're fine and they're doing everything that they should do for their age. I don't think it's something fundamentally wrong with them. Of course some of them are very disruptive but yet again other children are disruptive as well and they don't have ADHD. You just have to be aware that there is always a cause for their behaviour and you have to deal with the cause rather than the bad behaviour. At the end of the day I don't think you can blame it all on ADHD. As a teacher, you have the responsibility to treat every child the same and see them as individuals because in the same class you can get a child with Asperger's syndrome, one with ADHD or another child is poorly one day. (Sam-support staff)

> For me there are just badly behaved children. There's nothing wrong with them. I am treating them the same as everybody else. I do wonder sometimes if maybe I'm not being specific enough in my questions and that's why they don't understand. I think it's very easy to get confused. Some symptoms can mislead you. For example very intelligent children are getting easily bored. (Gillian-support staff)

The same idea was underlined by other Romanian teachers, who furnished descriptions of the complex situation faced by pupils diagnosed with ADHD in their class:

> I have experience with only one child with ADHD but the situation was very bad. To say he had only ADHD is too simplistic. He was in foster care. The adoptive parents had problems with alcohol and now the social services got involved. He is now sharing a flat with 5 other abandoned kids. It must be more than ADHD in this case. There is a whole bunch of other stuff that makes his problems not as simple as they would first seem. (Simona-teacher)

> Their behaviour is not great of course. I don't think you have to take it personally when a child with ADHD does something wrong. This can happen to any other student. It doesn't mean that he or she doesn't like you or that your teaching skills are inefficient. (Georgiana-teacher)

As a consequence, several teachers and support staff acknowledged that children diagnosed with ADHD can be taught successfully in mainstream classrooms. Teachers believed that students should be accepted, respected and loved, conceptualising children as "normal" and complete human beings. As Pearson (2009) has also found, these teachers foregrounded how society can create the barriers to learning and participation, and argued for inclusion which prioritises the subject and community of practice. For instance, one Scottish teacher emphasised the benefits of mainstreaming and the necessity that students diagnosed with ADHD be treated and taught similarly with their peers:

> Children with ADHD don't have major needs. They just need more attention from everyone. They are just very special children who are easily hurt. They are isolated children. Adults are isolating them because it's hard to understand their needs. They can do well in mainstream. ADHD doesn't change the way I teach. I know how children develop and what is best for them. I know how children with ADHD learn best and I can make them achieve according to their age. (Ruth-teacher)

Agreeing with the mounting evidence that many children identified as having ADHD are also very bright and creative children, a Romanian support staff called attention to a change in perspective and more understanding towards this category of students:

> We as teachers need to change the way we view these students. They are not placed in our classrooms to make our lives more difficult. They are normal and very bright children that can be successful in school. (Alexandra-support staff)

Furthermore, teachers' narratives functioned to resist the medical accounts associated with ADHD by becoming active agents in terms of power, control and expertise (Gray, 2008). Teachers' empowerment and control were implicated through dealing with children as autonomous individuals, knowing the child's strengths, and teaching guided by positive values and ethics. Therefore, acknowledging the environmental, structural and attitudinal barriers that children were facing, several Scottish teachers and support staff became empowered by taking the initiative to get involved, know more, provide advice and accept challenges:

> Children don't have to obey the teachers. The training should turn that around, aiming to show teachers how to praise good behaviour because there are good times as well. Although I don't like the reward systems, you need that system to deal with ADHD. But now that I think about it, I don't think we need training specifically for ADHD, because it can be applied to challenging behaviour as well. (Jennifer-teacher)

> I read a few books and I also have a friend who works in a special needs school. I really enjoy reading these books because training courses are more geared around how to deal with bad behaviour which you cannot use with children with ADHD. Some courses are better than others. You just take bits out and try to use them. I feel like I want a school with more challenging behaviour. (Michele-teacher)

Although teachers felt that there was a lack of opportunity for further development in Romania and the training they attended was mainly medically orientated, their participation was empowering and made them feel valued as professionals:

> There are not many training opportunities for ADHD in Romania although I like getting involved. The only one I took part in was called *Accept me, Understand me, Teach me*[7]. It was ok, better than nothing. (Paula-support staff)

[7] *"Accept me, Understand me, Teach me" is a project which promotes the early identification of ADHD, founded by the Romanian Minister of Education, the National Centre of Mental Health and the pharmaceutical company Eli-Lilly.*

> I didn't learn anything from the training I have attended because there is not much out there. Although I don't have the physical time, I would like to go. The last one I have attended was developed in collaboration with the School Inspectorate and the local psychiatric hospital. It was something about intervention in ADHD. (Clara-support staff)

On the other hand, reflecting the uncertainties in the literature, some teachers were confused about what actually causes ADHD and demonstrated the contentious nature of the ADHD phenomenon. For instance, one Scottish teacher expressed her ambivalence regarding the biological and social underpinnings of ADHD:

> I can't actually say what ADHD is or what is causing it. I'm not even sure if there is such a thing as ADHD or if it is something to do with prenatal development. Is it a biological thing or has it something to do with the social upbringing? I'm not very sure. I sometimes think that something is going on inside their heads but there are too many things that contribute to ADHD. (Ruth-teacher)

Considering the professional disagreement on what ADHD is or what should be done about it, one Romanian support staff described the complexity of the ADHD phenomenon. She acknowledged that ADHD can be genetically inherited, but other social factors might also contribute to the development of this condition:

> I am very confused, but the situation was very bad. I know it must be something genetic but there are a whole bunch of other factors making his problems not as simple as they seemed. (Paula-support staff)

6.3.2. Resisting the medicalisation of ADHD

6.3.2.1. The sample of parents of children diagnosed with ADHD

Analysis of participants' talk about treatment indicated two differing patterns of talk. Firstly, some mothers showed reluctance regarding the use of medication to treat children diagnosed with ADHD. As Gray (2002) also observed, interviewees actively resisted the medical coercion and pursued other resource options. For instance, mothers in the Sccotish sample felt that there was still too much negativity surrounding the use of medication and they were concerned about the side-effects especially related to the child's emotional status:

> I didn't want that Ritalin. I heard too many bad comments about it. I told the doctor I don't want Ritalin and I got another medication but the chemist told me that all the medications for ADHD have Ritalin in it. People told me Ritalin is a drug. Ritalin made him a zombie. He would stay in the nurse's office and not say anything. He wouldn't talk or eat. I felt so sorry for him and I threw away the medication: *"take all the medication and give me my son back"*. He wasn't laughing, he wasn't like a typical boy, and he was just sitting there. This Ritalin is too strong for him. (Linda-mother)

> My son is not taking any medication at the moment. We are taking a break. He used to take antipsychotics before and I know a lot about Ritalin. I was terrified to find out that it is a drug originally used for diets. We decided to take him off Ritalin. He was worse with medication. He was self-harming, cutting himself and having suicidal thoughts. He is better off the meds. (Francis-mother)

> Ritalin helped him with his behaviour but it made him like a zombie. He was so quiet, not moving and dragging his body about. He even stopped eating and we had to change his medication to Strattera[8]. (Anne-mother)

Experiencing adverse effects contributed to decisions to discontinue medication even when the child showed clear symptomatic benefits. One Romanian mother also acknowledged the negative side effects of medication on her son, saying:

> Straterra was very damaging. The first week he was ok and I could see an improvement. As the dosage increased, it became worse. (Diana-mother)

8 Classified as a norepinephrine (noradrenaline) reuptake inhibitor, atomoxetine is manufactured, marketed and sold brand name Strattera by Eli Lilly Company, being approved for use in children, adolescents and adults for the treatment of ADHD.

On the other hand, most of the participants interviewed in this study described feeling constantly pressured to medicate their children and this pressure came either from the school or parents themselves. In this context, Scottish mothers reported feeling frustrated and disappointed when schools and teachers told them that if they do not medicate their children, they cannot be in the classroom:

> Because I was receiving so many complaints, one day I went to the school and spoke with the psychologist. All they want is to medicate my boy. They want him to become a zombie, but he can't learn that way. I think the pills are too strong for him. That is the reason why I decided not to give him the medication during the weekend and holidays. He seemed ok. (Francis-mother)

> I used to get phone calls every day. A teacher once came to me in the playground and told me to go to the hospital and get him medicated. She did that in front of everybody. They don't have the right to say that because they are not doctors. (Anne-mother)

Attributing the clinicians' role to teachers, one Romanian mother commented about teachers' abilities to recognise ADHD and to appropriately recommend treatment. For her, medication was passively accepted as a last resort:

> I had to put my son on Concerta[9] because the teacher recommended it to me and she knows best. You know, he is really bad off medication. Once the teacher called me because she thought that the child didn't take the medication. His behaviour was extremely bad that day. (Ioana-mother)

Furthermore, both samples of Scottish and Romanian mothers reported that their child took medication primarily on school days, as opposed to weekdays and weekends when they can cope better with children's behaviour at home:

> I'm not giving him the pills during the weekend. When he is not in school, I can cope better with his behaviour. (Rachel-mother)

> He didn't take the medication for a week in the summer holiday and he was fine and cheery. (Cristina-mother)

[9] *Concerta contains the active ingredient methylphenidate hydrochloride, which is a type of stimulant medicine used to treat ADHD in children.*

> He went on a trip with his school for a week and he was brilliant. I was afraid he wouldn't do all the activities but he even went rock climbing and he loved it. He also likes horse riding. He has been practising that since he was 3 years old. Horse riding is the only thing he can do well with no medication. (Alina-mother)

Mothers' narratives showed that school played an enormous role in both persuading and deterring medication use. As the control was taken away from parents and children themselves, medicalisation was seen as a process of increasing the institutional power. The educational establishments take charge of the lives of children, using their diagnosis to overpower the wishes and decisions of parents. Although "schools have no business practising psychiatry" (Martin, cited in Graham, 2008b, p. 94), the reasons behind the schools' tendency to excessive medicalisation need to be interrogated. It could be the case that the vast majority of teachers who "diagnose" and "prescribe" were influenced by economic benefits. As Wheeler (2010) commented about the British education system, some headteachers might benefit financially when special needs funding is reallocated around children who are educationally classified as having ADHD. On the other hand, when children with a diagnosis of ADHD are not entitled to funding support, teachers are still under enormous pressure to justify and explain why some students with additional support needs are not achieving the benchmarks. In this new age of accountability measures, a clinical diagnosis "provides a medical explanation for under-achievement and enables schools to out-source the problem-child to the medical and psychological domains whereupon the problem may be neutralised via a prescription for stimulant medication" (Graham, 2008a, p. 98-99)

6.3.2.2. The sample of teachers and support staff

Similar patterns were identified within the sample of teachers and support staff. Several of them took into consideration the social context in which children were perceived as functioning inadequately and attributed ADHD causation to normative social factors. Although they were not very specific in their statements, several teachers and support staff had their own reservations about the prescribing of treatment and targeted both short and long-term effects of medication. Entwined with acknowledgments of medication side effects was the teachers' perception of the complexity, subtlety, and diversity of disabling barriers faced by children diagnosed with ADHD who are ultimately categorised with a social label. As Shaw, Gilliom, Ingoldsby, & Nagin (2003) have also observed, they believe that children who behave badly are labelled inappropriately with ADHD and treated with stimulants. For instance, although they felt that the specialist should have primary responsibility for the ongoing assessment of children with this condition, several Scottish teachers and support staff made reference to the damaging side effects of medication, being aware also that a positive response to stimulant medication could not be used to confirm the diagnosis of ADHD:

> One of the biggest things for us as teachers is the medication side of things. Sometimes medication is given out without any reason. From what I read some very strong drugs are prescribed. No one is considering the side effects. I don't like young children taking such strong medication (r*eferring to Ritalin)* but this is just my opinion. I don't have any medical background. (Michele-teacher)

> I really don't understand this positivity towards medication. Not every student benefits from medication. There must be more to this ADHD than a pill. Ritalin is an amphetamine derivative. It is a heavy drug, which you can get a lot of bad side effects from. I know cases when children were first prescribed Ritalin and then the diagnosis given. (Sam-support staff)

The idea that individual bodies might be harmed by the use of medical treatment was reinforced by one Romanian practitioner who expressed her preference for using more evidence-based instructional strategies:

> We have 35 children in the class and several of them have problems. I can cope with all of them just using the strategies I have learned. The point is to get the benefits without the negative effects that a hard drug has. (Alexandra-support staff)

Parents were also seen as responsible and conceptualised as active agents of the absurd process of medicalisation. Defining normality was unquestionably a difficult task for one Scottish support staff who thought that children's behaviour was misunderstood as pathological by parents:

> I don't think medication could replace parental responsibilities. Sometimes I'm wondering if maybe parents need to be medicated, not the children. They use this medication because they don't want to take responsibility.

> You can't actually medicate a child if he's displaying some sort of normal behaviour. It is easy to give some pills but it's always hard to be a good parent. (Naomi-support staff)

Great awareness of controversy surrounding ADHD treatment was elicited by one Romanian practitioner. She considered that treatment should be used differentially according to the frequency and severity of the ADHD symptoms. Such a view requires an understanding of the individual and social bodies as inherently interconnected, which implies that causes of distress are always responses to, and reflections of, the social context. Consistent with Snider, Busch, & Arrowood's (2003) study, she agreed that a pill could not undo years of poor habits, change someone's intelligence or reverse the cumulative effects of academic underachievement:

> It's very hard to have an opinion about treatment. I think it depends on how severe the disorder is and how bad the symptoms are. For the most part, I would be very sceptical like I would be for any type of medication. Some of the children are just so disruptive, you can't make them sit down and maybe some medical help would be beneficial. But other children are just a bit distracted and they don't achieve like the rest of the class. But students are not equal. We can't have a country full of academics, doctors and engineers. I don't think medication will make anyone more intelligent. It might sound funny but I feel that with ADHD, it's like we medicate to prevent stupidity. (Clara-support staff)

6.2.3. The educational and medical "wrongs"

6.2.3.1. Fromm's notion of social character

Fromm's (cited in Veck, 2012) notion of social character represents an appropriate framework to understand parental and teachers' accounts. Fromm suggested that the way in which ADHD is understood cannot be located in either the individual with its biological basis or in the economical or material basis of society. Instead the conceptualisation of ADHD is placed as the intermediary between the socio-economic structure and the ideal and ideas prevalent in society. The attitudinal patterns, the structure of the medical system and the pressure coming from either parents or teachers played prominent roles in the development of ADHD schemas. Children were no longer considered to be disabled by some medical dysfunction or by an irrational society. Instead, children diagnosed with ADHD were disabled by the "wrongs" that happen to them within the social, medical and educational environments.

Indeed, findings from this study illustrated the complexities of the "wrongs" experienced by all the participants in this study. Although emotions varied from one situation to another, their experiences were generally confusing, overwhelming and fuelled by negative public perceptions. According to Parer (2000), emotions were painful, confusing, disorderly and unlikely to be neatly resolved. Indeed, for both samples of Scottish and Romanian parents, teachers and support staff, the "wrongs" done to them ultimately led to frustration, pain and withdrawal.

6.2.3.2. "Wrongs" done by teachers and the education system

6.2.3.2.1. The sample of parents of children diagnosed with ADHD

According to the social model of disability, the educational difficulties experienced by disabled children in the regular classroom are not necessarily caused by their individual impairments, but might rather be the result of a poorly-developed education system that is not equipped to meet the needs of a diverse student population. Almost all the mothers interviewed believed that they are victims of the current education system. According to Runswick-Cole (2008), these stories suggested the need to remove barriers to children's learning. Because school budgets are extraordinarily lean, mothers considered that many children missed out because of the way their difficulties were described in school. Children need to fend for themselves in a system which sometimes seemed designed to thwart their efforts. Indeed, mothers made reference to the attitudinal, physical and organisational obstacles created by the education system. Their main concerns were related to how the classroom environment could be changed, how the curriculum could be adapted to childrens' individual style of learning or in the way in which the communication between home and school could be improved. More importantly, consistent with the social model, dealing with the disability per se was not the greatest problem for mothers participating in this study. Rather, it was the lack of teachers' understanding and professional support that was the most challenging. For instance, what was perceived as hyperactivity was not an outcome of impairment, but the outcome of being situated within segregated social environments. According to Fromm (cited in Veck, 2012), children become disabled and

oppressed by the "wrongs" that happen to them within the school where teachers still hold stigmatising attitudes, use inappropriate teaching methods and provide inadequate support.

Both samples of Scottish and Romanian mothers reported ongoing experiences of feeling like they were not heard or understood by teachers from whom they were entitled to receive help. Mothers from this study perceived that teachers did not take ADHD seriously, were ignorant about ADHD, and what little they did know about ADHD was stereotypical. Overall, Scottish mothers expressed a shared belief that ADHD was poorly understood:

> Teachers are very ignorant of ADHD. I have asked the nurse to come to the school and speak with the headteacher and explain what ADHD is about. They got letters from the doctor explaining what ADHD was and they still don't want to understand it. They just can't be bothered. (Linda-mother)

> I can't have a discussion with the teacher, she knows better, that's the attitude: *"you are making excuses for the child's behaviour"*. A student was supposed to come to the school and do a presentation about ADHD, but the headteacher cancelled the meeting because my child's behaviour was bad that day. How helpful was that? (Francis-mother)

Several mothers from the Romanian sample also believed that teachers did not possess enough knowledge about ADHD and often crititicised their arrogant attitudes:

> Some teachers just don't have a clue about what ADHD is. The doctor explained what was wrong with my boy. I think it's time for the school to change. They need to understand ADHD more. (Ioana-mother)

> Education needs a better understanding. ADHD is increasing, and it is increasing because it is being acknowledged more or for other medical reasons. Schools need more knowledge about ADHD. (Maria-mother)

Mothers from both samples seemed to blame their child's difficulties on the teachers who were failing to adequately address their children's needs. When a child falls behind, parents blame teachers mainly because they have idealistic expectations and they often expect the highest physical, emotional, and intellectual standards of themselves and their children. According to Bull & Whelan (2006), unrealistically high standards could lead to emotional exhaustion, depersonalisation, and depression. For one Romanian mother, the tension between her demands and reality resulted in feelings of hopelessness and frustration and caused additional stress:

> You have to be very firm as a parent but fair at the same time. It is really hard, but not impossible. It is just a matter of wanting your children to do better. (Diana-mother)

On the other hand, Scottish and Romanian mothers emphasised that, although teachers are essential in providing support, a parent knows more about their child's needs than anyone else. Parents started from the assumption that children's behaviour should be similar at home and school and argued that the strategies they adopted would necessarily work within the educational settings. Therefore, mothers underwent a big transformation. If previously they considered themselves as victims of an unsupportive education system, they then became experts who could offer a definitive solution. For instance, this cognitive repertoire allowed Scottish mothers to start providing suggestions about how teachers could change their behaviour and improve their teaching skills:

> Teachers are very negative and usually use words like *"stop it"*. Once I asked the headteacher if I could stay in the class during a lesson. The teacher was always saying "*you have to stop that now, this is not acceptable in my class, you will taken out of the class if you don't behave"*. I don't think it is acceptable to treat him like that. (Rachel-mother)

> Sometimes I think the school underestimates his abilities. He came home once with homework which was for a 3 years old. I think this is ridiculous. They didn't even challenge his mind. He wasn't even given a chance to do better. (Francis-mother)

Furthermore, one Romanian mother become an expert in child development issues and envisioned different ways of being a teacher:

> Teachers expect to dominate a class but you cannot dominate ADHD. The more you try to dominate ADHD, the more ADHD fights back and dominates you. Instead of dealing with ADHD, they are just dealing with their lack of respect and their incapacity to dominate. A teacher like that should never work with children with additional needs. You have to relate to the child and get the child to relate to you. You cannot dominate ADHD. I know that they need to control a lot of children and if someone cannot be controlled you punish, instead of helping, because that child proved you wrong or embarrassed you. Teachers need to find another way to deal with ADHD, not dominance. (Cristina-mother)

Mothers' negative attitudes towards the education system were also influenced by a sense of their children being excluded and bullied by their colleagues. Bullying contributed to a social hierarchy of privilege and oppression where the child diagnosed with ADHD became the loser who was denigrated and ostracised.

Once again, both samples of mothers reported that their children were disabled by name-calling, gossiping, violence spiteful remarks, malicious rumors and banishment from social circles or school activities:

> There is an issue with one girl who has a lot of other problems. She has ADHD as well. To me, a child like that has to be in a special school or she has to have a support teacher all the time. She has to be taken out. She is just annoying my son, hitting him, beating him and sticking a pencil in his skin with no reason. I know my boy is not an angel. I don't make excuses for anything, but he gets punished by the teachers because of this little girl. (Anne-mother)

> He is currently in two classes within a mainstream school: a special class with 6 other children in the morning and a normal mainstream class in the afternoon. It is like a *"handicapped"*[10] class. He is brilliant in the small class but he gets bullied in the mainstream because he's going to the *"handicapped"* class. They are picking on him because he's in that special class. They think he's daft but I strongly think he needs special support and I also think teachers treat him differently because he has ADHD. (Alina-mother)

[10] *Although a derogatory term, the word handicapped was translated from Romanian into English, having the same meaning and usage (e.g. Romanian-handicapat)*

6.2.3.2.2. The sample of teachers and support staff

Teachers' and support staff's accounts might be also heard as describing the "wrongs" often associated with teaching. The good teacher device was used to reject the educational practices related to ADHD which draw upon medical knowledge and specify constitutional difficulties. The philosophical roots of various Romanian teachers' narratives were instead located within a social model of disability that views the maladaptative behaviour associated with ADHD as the product of inevitable discourses of environmental and structural contexts, rather than the result of an individual's genetic or neurological impairment. Culture, politics and society create ADHD and are the arbiters of disciplinary powers that produce and reproduce pathological understandings of different bodies and minds (Goodley, 2001). Teachers and support staff from the Romanian sample adopted the position that ADHD might be caused by inadequate classrooms and a lack of appropriate teaching materials (environmental barriers), segregated schooling and inefficient educational system (structural barriers) or negative attitudes of older staff and the absence of a professional ethos (attitudinal barriers)

Therefore, before asking why children diagnosed with ADHD are discriminated against and not treated as equals, we might also want to ask why teachers can't or won't teach. Indeed, it is important to understand that the structural and attitudinal barriers faced by teachers are indirectly experienced by children as well, which in turn will affect the way in which children diagnosed with ADHD are educated within the classroom. Teachers and support staff from the Romanian sample perceived themselves as victims of an ailing education system that was structured to guarantee the failure of all the actors involved. The

process of teaching in Romania was frustrating, unrewarding and intolerably difficult. Low salaries and lack of professional development opportunities were a signal that educators lacked importance and value:

> The salaries are just too low and the humiliation is hard to bear. I'm a teacher but I am qualified to be a professor within the university. In other European countries the salary for a primary teacher is a decent one although they have to spend 8 hours per day in the school and of course they have more time and patience to deal with challenging behaviour. (Amalia-teacher)

> It is hard to explain to you how I feel. Students with ADHD are solely the responsibility of teachers who need to do a multitude of things at the same time, an activity for which they are not professionally trained or adequately paid. Instead of watching TV and listening to the politicians' lies, we need to do something. Maybe if more money were to be invested in education, we could reach the Japanese level. (Clara-support staff)

> The educational system tried to make some changes in the past years but I don't think the changes were based on quality. How the school is structured today doesn't fit children with ADHD. It is just an old system, which didn't change from the moment it was invented. I would just tell you one thing. When the state is not paying teachers and staff, the children will pay. (Alexandra-support staff)

In this study, teachers and support staff also mentioned sociological phenomena such as the loss of professional ethos and unsupportive attitudes about the ability of a child diagnosed with ADHD to succeed. For instance, one Romanian practitioner reported attitudinal barriers regarding the lack of understanding, knowledge or effort by older educational staff. She complained about other colleagues having different ideological orientations about the purpose of schooling, students' learning and the relationship between school and society:

> My problem is with older staff. They've been trained to use very old-fashioned teaching methods and they don't know how to communicate. When a young teacher like me comes along with original and new ideas, they think this is a competition and they try to stab me in the back, gossiping and so on. It is absolutely pathetic, not to say sad, how some teachers lack any sort of professional ethics. Children with ADHD are suffering. They got to the point for them where school is completely uninteresting and useless. (Paula-support staff)

In this study, particular concern was expressed regarding the very meaning of the teaching profession and the ethical standards connected with professional teaching practice. In line with Day's (2004) comments, one Romanian teacher posited that, in a world characterised by change and uncertainty, the meaning of teaching was lost, people became cash rich and time poor, and the emphasis moved from the community and civic wellbeing onto personal gain and benefits. Within an instable education system, teachers were no longer able to make a difference:

> I think it is very unfair how primary school teachers are treated. Years ago teaching was a vocational thing, coming from inside, something noble, but this is just history now. I still believe that teaching is a gift and teachers are shaping the emotional and psychological development of every student but we need to be respected more. (Amalia-teacher)

6.2.3.3. "Wrongs" done by the medical system and the support networks

6.2.3.3.1. The sample of parents of children diagnosed with ADHD

The kinds of stories that participants narrated about their relationship with the medical profession varied considerably according to their own personal experience and their conceptualisation of ADHD. However, in many cases, lack of understanding and mistrust of medical professionals by both Scottish and Romanian mothers was reported. Firstly, the main area of concern was related to the difficulties of clinicians in communicating with parents in order to coordinate care. Because communication was often impaired, mothers in the Sccotish sample described how they were left to navigate the confusing and stressful process of finding the way around the medical system by themselves. In Romania, medical professionals were armed with considerable professional vocabulary or jargon that disempowered mothers who were unable to formulate their views academically, in their language:

> We are extremely cross with the medical profession. You don't have enough time with them. Usually they are running late and when you are there, they use this fancy language so you end up more confused than when you first came to see them. It is very difficult to understand what they are saying and they don't understand you either. (Diana-mother)

For most of the parents in this study, the stigmatising attitudes coming from health professionals inundated them with messages of hopelessness. According to Kearney and Grifin (2001), ADHD holds a multiplicity of negative meanings, resulting in societal attitudes and practices that are dehumanising and which lead to social exclusion both of children and their families. When lack of support is combined with inadequate services, isolation often results: "It is precisely this lack of societal acceptance and absence of adapted resources that can transform impairment into disability, according to the social mode" (Thompson cited in Home, 2002).

On the other hand, mothers thought that their presence in various support networks did not help them to handle the illness or to support their children in coping with the disorder. Although, the purpose of family support programmes is to provide services to families that empower and strengthen adults in their roles as parents, nurturers, and providers, mothers found the support and resources available unhelpful. Indeed, as Walmsley (cited in Chappell, Goodley & Lawthom, 2001) has ascertained, these movements tend to emphasise issues associated with negative labelling rather than the consideration of disabling social and economic structures as set out by supporters of the social model.

More specifically, mothers in the Scottish sample expressed great negative emotional intensity and often complained that they did not have the time to attend support groups:

> I don't know but I just don't have time for this. I need to make dinner, take the kids to school and manage behaviour. I'm just too tired all the time. I don't have money for a baby sitter. I can't be bothered. (Francis-mother)

According to some participants, support groups contributed a pervasive negative view of ADHD. On a micro level, several Romanian mothers also claimed that support groups unhelpfully sensationalised ADHD:

> I have been to several parents' groups in the past but I think those meetings only presented false and negative information about ADHD as a disorder, not a condition. It was a waste of time and didn't achieve anything. It was very tiring as well because all parents think that their kid is the worst. There was just too much negativity. (Cristina-mother)

6.2.3.3.2. The sample of teachers and support staff

Mainly Scottish teachers and support staff were concerned with structural barriers related to their involvement in medical diagnosis whereby they were required to complete various rating scales. Many of them made references to the inadequacies of *Conners' Rating Scale*[11]. According to some of the teachers, medical practitioners were contravening health policy guidelines for ADHD by placing too much importance on the family environment and refusing to consider how children behave within the school context. Managing the bureaucracy and paper tracking mandated by health care providers was often overwhelming for teachers:

> I'm really annoyed about this Conners' Scale. I don't know how much information you have about this. It is a thing you have to fill in every now and then. A list of symptoms that children exhibit at school, things like how they complete the task, how they behave and so on but that list is so wrong because every child is different and how you judge their behaviour is very much related to our skills as a teacher. Doctors say that the child has to display the symptoms of ADHD in more than one context but very often the problems don't manifest themselves in school. Their behaviour is different in different contexts. (Jennifer-teacher)

[11] *Conners' Rating Scale is an assessment battery for children aged from 3 to 17 years designed to measure cognitive, behavioural, and emotional problems from teachers' and parents' perspectives.*

In addition to medical incompetence, there was also the invocation of undue parental pressure on the diagnostic process. From Scottish teachers' and support staff's point of view, the objective nature of the ADHD diagnosis criteria determined parents and health professionals to approach students with ADHD as being weird and different from others:

> I'm really annoyed about the letters we get from the hospital. We need to fill in tonnes of reports, a fuller exploration of the child in class. I wonder if anyone reads our suggestions because the outcome is always a diagnosis and medication. (Ruth-teacher)

Several Scottish teachers and support staff described the practices of medical assessment for ADHD, implied medical failings and had claims oriented to accounts of over-diagnosis. Furthermore, they argued that schools and teachers were not to be considered collaborating professionally in the field of ADHD. How Scottish educators felt was in contrast to the vast majority of research in the field that underlined that teachers were central and influential in terms of identifying the difficulties of ADHD, taking part in the diagnosis process and monitoring treatment. One explanation is that teachers and medical practitioners might have contradictatory beliefs about ADHD which inhibits effective communication and coordination of care. Medical practitioners may subscribe to the systems of care philosophy, which assigns the coordination of care to mental health agencies. Teachers, however, may subscribe to the social model of ADHD in which care is overseen and coordinated by parents or school staff.

It seems that, at times, the way in which ADHD was conceptualised managed to set one profession against the other:

> I have a personal problem with the GPs. ADHD is over diagnosed. The GPs don't have the expertise to diagnose ADHD. It is too complex and difficult. GPs are best to stay out of this. Parents don't have time to deal with it adequately. It is too complicated and difficult. We need to work more as a team and explore different ways of helping children with ADHD. (Gillian-support staff)

> There was not much joined up thinking between the agencies. I went to some review meetings at the school involving staff, parents, social workers and the health visitor but the child's consultant from the hospital was never there. Before the child was put on medication, we had very positive feedback about the school behaviour but the doctor was not there to hear all the positive things about the child so you don't know what the mother is saying to the consultant. Why didn't the consultant speak with us to see how he was doing before deciding the treatment? (Sam-support staff)

6.4. The concepts of blame and disablement

The data showed that blame issues emerged as an important and common theme. Both samples of Scottish and Romanian mothers, teachers and support staff entered a vicious circle of disablement and blame, which became externalised to their own person, children, institutions or diagnoses. Despairing over the ADHD chaos, parents blamed and disabled teachers and the educational and medical system, teachers blamed the education nd medical system and disabled parents, and all of them blamed and disabled children and their condition.

Descriptions of blame and the meanings associated with the process of disablement were unique and particular to each participant. The results illustrated various constructions of blame, where blame was internalised or resisted by transferring the responsibility to organic factors, social actors and spaces. On the other hand, disablement was vividly experienced by both mothers and teachers and more importantly by children labelled as ADHD.

6.4.1. Self-blame

6.4.1.1. The sample of parents of children diagnosed with ADHD

The study revealed that several mothers of children diagnosed with ADHD blamed themselves for their child's disorders. Mothers spontaneously talked about their feelings of inadequacy and blamed themselves for the nightmare caused by ADHD. Although the question *"do you feel guilty"* was never addressed, ideas about morality and how to be a good mother were present in some narratives. According to Singh (2004), mothers' emotional reactions were the results of a variety of social and cultural factors that supported the good mother ideology and reinforced mothers' feelings of self-blame and guilt. This constellation of factors drained energy from mothers, further isolated them, and left them feeling as if they had a moral responsibility to find a fix.

Furthermore, as Wheen (2011) ascertained, mothers' beliefs that they are causing the perceived behaviour could be seen in contrast to the rhetorical investment in ideological views of the parent as nurturer. Indeed, according to Bennett (2007), the existential consequences of the internalisation of blame might be extreme.

The stress and effort of raising a child diagnosed with ADHD determined onr Scottish mother to disable themselves by thinking that she did something wrong:

> I feel like I failed as a parent, that it's my fault he's like this. His dad died when he was 3 months old and I brought him up myself. Maybe if I had done this, didn't do that, if I could have changed this, how would he be? Did I give him too much of what he wanted when he was young? (Linda-mother)

Further, the data suggests that blame was also confidently accepted by mothers in the Romanian sample. For instance, one mother blamed herself for a lack of parenting skills and described the mental and physical exhaustion caused by her child's frequently inappropriate behaviour:

> I feel like being a parent it's nothing more than a job. The job is to make kids and take care of them. But it is a damn hard job. I often praise myself for having to put up with this entire nightmare. I try to ignore the bad behaviour when that's possible but I'm so fed up, really. I'm a very compassionate and a soft person but he drives me mad. I feel like I had failed my own child. It is exhausting because you are trying your best all the time. Once I had a really bad nervous breakdown. (Alina-mother)

6.4.1.2. The sample of teachers and support staff

Both samples of Scottish and Romanian teachers and support staff started by pathologising their pupils and finished by blaming their teaching practice or their profile of competencies. Blame became a coping mechanism associated with a set of cognitive and affective responses which arose in response to a concern about being unable to implement best practice in the classroom. Several Scottish and Romanian teachers and support staff choose to pathologise themselves, coming to the conclusion that that they will never make a satisfactory, let alone a good teacher, no matter how hard they strive. This self-blame is reminiscent of Bourdie's (cited in Moore and Atkinson, 1998) notion of the relation between subjective expectations and objective probabilities. For those teachers who may give themselves the command to improve their practice to fit with their sense of what is desired "a pervasive sense of guilt often haunts" (Helsing, 2007, p. 1321). This led to a situation in which teachers fall back on their own inadequacies as the explanation for the children's behaviour. For instance, many practitioners blamed their own personality characteristics for the failings, reported self-blame and sense of inadequacy.

6.4.2. Brains and genes

Perhaps one of the most interesting subthemes derived from the explanatory medical narrative of ADHD was the way in which the diagnosis of ADHD seemed to remove the stigma of parents' and teachers' inadequacy and shift the responsibility away. Mothers and educators in this study resisted blame by using a medical discourse of ADHD where the focus was moved from them to the children's brains and genes. In order to be morally absolved both samples of Scottish and Romanian mothers, teachers and support staff acted as agents of medicalisation. No one could be held accountable for the potential problems and medication was perceived as a tool that provided the only means of control. According to Wheen (2011), medication served the role of alleviating the sense of blame and therefore reinforced the oppressive cultural ideology of the good mother and the good teacher.

Interviewees appeared to acknowledge that the child is cast in the role of victim which made them less responsible for the potential consequences. All actors involved in the child's life became victims of a label and attributed their children's difficulties to the fact that they had a medical problem for which they are not responsible. According to Parer (2010), the medicalised understanding of ADHD could enable a morally dubious use of the ADHD diagnosis as a means by which to be absolved of responsibility and guilt. ADHD provided a medical explanation for underachievement, allowed re-evaluation of past behaviours, shifted responsibility and reduced blame (Conrad & Potter, 2000).

Since organic causes are not morally accountable (Singh, 2004), this model suggests that no one could be held responsible for the disorder. When mothers and teachers succeeded in locating the cause of their child's misbehaviour, the diagnosis brought relief and exoneration from blame. According to Barkley (1998), when the biological and genetic contributions towards ADHD are acknowledged, it becomes absurd to make moral judgements about the worth or character of parents and teachers. In this way, the confirmed medical diagnosis of ADHD could sweep a culture of mother-teacher-blame into absurdity. Again, participants' perceptions seemed to be based on the idea that poor self-control is the most important and pervasive individual trait associated with ADHD behaviour. Children have no control over their actions when the disorder starts to dominate their personality and becomes a part of their whole identity. These stereotypes served the function of constructing ADHD as a dangerous, debilitating and irresolvable problem that encouraged generalisations from the ADHD itself to the whole person (James & Prout, 2001).

6.4.3. The process of finger pointing

6.4.3.1. The sample of parents of children diagnosed with ADHD

The phenomenon of ADHD sparked various rounds of finger-pointing between parents, teachers and other stakeholders. Firstly, this study illustrated how mothers of children diagnosed with ADHD experienced stigma and alienation from school. Many mothers in this study felt that they and their child were treated differently as a result of the child's medical diagnosis. From their point of view, teachers tend to have judgemental attitudes and blamed children for their inappropriate behaviour without questioning the reasons behind their actions. As Parer (2010) explained, the stigma of ADHD was not only limited to actual behaviour, but also included the dangerous image of the disease. According to some mothers, children were always blamed in the classroom and teachers considered that they deserved to suffer the consequences of their actions. Mothers also reported that teachers were irritated and unsupportive, blaming the child for his or her behaviour, and suggesting that they were doing it on purpose.

These narratives might help to explain why many mothers believed that the child's pathology was caused by dysfunctional patterns within the school environment. Considering the social concepualisation of ADHD, it was not surprising that mothers started blaming their child's extreme difficulties on the inadequate teaching strategies or the incapacity of the education system to efficiently address their children's needs. By attributing responsibility outside of both themselves and the child, mothers attempted to establish control over a situation that was perceived as hopeless. In this way, mothers conquered the situation by explaining it, however erroneously.

The disablement lay in the construction of society, not in the physical condition of the individual. The sense of disablement was more implicit and came about because of teachers' attitudes, their failure to accommodate students, the bureaucracy of schools and the structure of the entire education system. Mothers in this study argued that expert teachers were using their power in a coercive way leading them to feel isolated and silenced. For several Scottish and Romanian mothers, education represented a scenario whereby people were disabled, disempowered and marginalised.

6.4.3.2. The sample of teachers and support staff

In this study, teachers and support staff worked up the social conceptualisation of ADHD as related to parenting issues which appeared as an alternative explanation to ADHD. According to Gray (2008), teachers indirectly implied that the child learned such behaviours rather than inherited a biological condition. It was significant that in drawing from environmental factors in this way, the emphasis was placed on parental influences as opposed to educational causal explanations, which meant that teachers succeeded in eliminating their own accountability for the consequences of ADHD. Furthermore, there was also the invocation of parental pressure on the diagnostic process. The diagnosis was imposed upon the individual by parents, the medical profession was constituted as under pressure and parental motivations were seen as creating the need for medicating away the differences in children away. However, as Gray (2008) ascertained, in the face of such claims of misdiagnosis and mistreatment, external responsibility was transferred from the educational setting to the parental environment.

In resisting medical explanations, teachers also favoured accounts which produced instances of misdiagnosis and lack of co-operation with parents and extended families. As a consequence, they shifted the blame again and emphasised the inherent incompatibility, competition and conflict between families and teachers:

> We get a lot of headaches from parents who want the diagnosis. They come to school and tell us: *"could you please complete the form, he's very bad at home and so on"*. In other words we kind of have to rate something which you don't see happening in the class because parents are so persistent. (Ruth-teacher)

> I don't have good memories about working with parents. You feel like they are patronising you. They just play with their child's health. Many of them are in denial. They see problems everywhere. They think that the child is not normal. There are a lot of children over diagnosed because parents are blinded. (Georgiana-teacher)

7. Cross-cultural comparisons between Scotland and Romania

7.1. Introduction

In his book *Modernity at Large*, Arjun Appadurai (1996) describes the cultural logic of globalization as a series of imaginary landscapes made of ethnoscapes, mediascapes, tehnoscapes, financescapes and ideoscapes, that defined historically situated imaginations of person and groups spread around the globe. As argued by Roosa (2000), consideration of the cultural background alone does not provide an accurate understanding of parents' and teachers' knowledge and attitudes because it fails to acknowledge the fluidity of knowledge and attitudes in response to contextual demands. According to Diaz (2009), culture cannot be considered as a static construct, but rather as fluid and dynamic entity that varies within and across the multiple groups of individuals. Therefore, particularly relevant for this study is Appadurai's understanding of globalisation which entails the understanding of the complex, dynamic and interactive processes of flows and scapes. The shift in one scape determines the shift, movement and transformation of all the other scapes. As Appadurai (1996) noted, the relationship among ethnoscapes, mediascapes, ideoscapes, technoscapes and financescapes is disjunctive and unpredictable because each scape acts as a constraint and a parameter for movement in the other.

Children diagnosed with ADHD, their parents and teachers seem to be in the middle of these disjunctive connections between movements, flows and transfers. As the world becomes increasingly interconnected through political, economic, technological,

ideological and media scapes, the sphere of the family and school becomes the primary arena where globalising processes are realised. According to Anderson-Fye and Floersch (2011), the recent globalisation of mental illness diagnoses and of psychiatric pharmaceuticals means that schools and families are arguably key sites where culture, policy and practice intersect at a transformative developmental moment for children. Mothers and teachers become a part of worldwide flows of people, information, images, and products such as prescription drugs (Appadurai, 1996).

As Chew (2012) has observed, families and schools stretch and strain to accommodate the requirements of the ADHD diagnosis, simultaneously transforming themselves into active agents able to engage with the forces of globalisation. Globalisation can be accepted, contested or subverted according to parents' and teachers' constructions and fabrications in which the imagination plays an important role. Indeed, people live in imagined worlds, underlying the significance of imagination as a social practice where mothers, teachers and support staff are in the middle of the flows and cascades of scapes.

Another important aspect was that, in Appadurai's terms, children diagnosed with ADHD, their mothers and teachers could be seen as a minority group that is displaced and marginalised. Both families and schools could be conceptualised as a site for passive acceptance or resistance because they might be included or excluded in the same way that minorities are. This was reflected in the way in which all participants blamed themselves for the ADHD chaos, blamed each other or shifted the blame to the brain or the educational and medical systems. There was a flow in the scapes just as there was a flow in mothers' and teachers' notions of blame.

Appadurai's theory of scapes was employed as a lens to look again at the data gathered to address research question 3 and 4 from a distinctly cross-cultural perspective. The analysis focused on specific variables, understanding different concepts and building knowledge that sheded light on the most important similarities and differences between the Romanian and Sccotish contexts.

7.2. Research question 3: To what extent do significant similarities in knowledge and attitudes exist among the Scottish and Romanian samples of parents, teachers and support staff?

7.2.1. The globalisation of emotions

The first key finding of this comparative analysis was that, after administering the self-report questionnaire and conducting the semi-structured interviews, several similarities between the two countries were elicited. Although some of the differences were statistically significant, when triangulated with the interview data, the results showed that Scottish and Romanian mothers, teachers and support staff expressed similar emotional patterns.

Indeed, as people move, ethnoscapes change. As technology is moved around and invented, technoscapes change. As capital moves around the world as part of the global economy, financescapes change. Extension and changes in the reach of media from different places cause mediascapes to change. When ideas are exchanged and spread, ideoscapes change (Appadurai, 1996). Taking into consideration these rapid changes, both

Scottish and Romanian mothers, teachers and support staff seemed confused and reported contradictory feelings of either pride and happiness or frustration and anger when dealing with children diagnosed with ADHD. Although some participants told a story that they perceived as positive (e.g. feeling happy, being loved, or feeling safe), they also engaged in discourses filled with tears, hardship, violence, loss, isolation and struggle for survival.

7.2.2. The globalisation of symptomatology

What was more evident within the qualitative and quantitative data analysis was the fact that the symptoms and other characteristics of ADHD were similar in both cultural settings. In line with Mah and Johnston's (2008) study, no major differences in attributions were found between the two cultural settings. Only minor differences were recorded in relation to the Scottish sample, where ADHD was mistakenly identified with some sleep problems experienced by children. On the other hand, the alternative terms used by Romanian mothers and teachers to describe ADHD were remarkable. When asked to define ADHD and its characteristics, they employed negative terms like mentally ill, retarded, handicap, handicapped or children with handicap. These negative social representations of disability had certain features that were specific to the national political, social, and cultural contexts. According to Ciota and Van Hoveb (2010), Romania is still renowned for being "the country of the handicapped, emphasised by decadent western societies". (p. 529) However, the classical symptomatological triad of ADHD, namely inattentiveness, hyperactivity and impulsiveness was spontaneously reported by Scottish and Romanian mothers. Participants affected by the demands of globalisation described symptoms in line

with the DSM IV-TR criteria of diagnosis, including high levels of hyperactivity, short temperedness, violence and sibling rivalry.

Although the definition of normality and deviance is culturally determined, the present findings might suggest that the cardinal ADHD-like symptoms that form the basis of the diagnosis present many similarities in both systems. Scottish and Romanian mothers might have different interpretations, perceptions, values and beliefs, but, according to Rohde et al., (2005), ADHD exists across cultures and has a cross-cultural validity. In this sense, Appadurai's (1996) notion of homogeneity can help to understand ADHD as a global phenomenon which has similar manifestations in different settings. Indeed, at this stage it appeared that ADHD was a universal, rather than culturally specific disorder, which was best conceptualised by participants as being a stable construct across both cultures with strong neurobiological or social correlates. However, this does not imply that bureaucratic and socio-cultural influences are denied and dismissed. Although the experience of ADHD is recognisable across different cultures, mothers seemed to agree that clinical presentation may vary significantly and that globalisation is likely to influence both idioms of distress and pathways to care. Appadurai (1996) among many others, has discussed the postmodern life, including the global transmission of people and cultural forms despite the boundaries marking nation-states. Similarly, according to Timmi and Taylor (2004), globalisation means the import and export of the cultures and may reduce politics to the administration of sameness. The export of the notion of diagnosis is inextricably connected to the export of modern constructions of "normal" and deviant childhoods. The conception of childhood mental health and symptoms like hyperactivity, inattention and impulsivity appear to be spreading across cultures, replacing old ways of viewing and experiencing mental distress.

Furthermore, despite the world-wide ADHD pandemic, medical professional groups (e.g. The American Academy of Paediatrics, The American Academy of Child and Adolescent Psychiatry or The American Medical Association), diagnostic criteria used around the world (e.g. The Diagnostic and Statistical Manual of Mental Disorders), treatment options (e.g. Ritalin), standardised instruments developed in United States (e.g. The Achenbach System of Empirically Based Assessment) or American experts on ADHD (e.g. Dr. Russell Barkley) are examples that ADHD could be a product of American society. In this context, in order to understand the similarities between Scotland and Romania, it would be useful to think about how the ADHD diagnosis travels from one culture to another and how numerous interpretations of the diagnosis "are real within their own regime of truth" (Prout and James, cited in Chin, 2003, p. 118). According to Ritzer (2004), in a McDonaldized society, people rarely search for the best means to an end on their own. Rather, they rely on the optimum means that have been previously discovered and institutionalised in a variety of social settings. In this sense it could be argued that mothers, teachers and support staff in this study have become Americanised by adopting a certain cultural understanding of ADHD and abandoning the fuller national, cultural considerations. This impression was reinforced by the perception within the literature that ADHD may stem from social and cultural factors that are most common in American society.

The data therefore provides a clearer understanding of the imported American ideoscapes which have promoted specific descriptions of both individual symptoms and clinical-level ADHD behaviours among mothers and teachers. In line with Appadurai's theory, for Scottish and Romanian participants, the exposure to a culturally biased

diagnosis and the predominance of American research into this disorder over the past 40 years was accompanied by specific culturally rooted childhood values that permeated both cultures. For instance, both samples discussed the ADHD symptoms in relation to the importance of academic achievement and education as a primary aspiration for their children. In sum, the imported ideoscapes discussed herein are likely to have an important influence on the manner in which Scottish and Romanian mothers, teachers and support staff described, evaluated and responded to children's behaviour.

7.2.3. Willingness to get involved within the Scottish and Romanian samples of parents

The experiences of parents' involvement in different training and activities revealed surprisingly similar responses for both Scottish and Romanian samples. Scottish mothers indicated that they need new ways for communicating with the school staff, parents' groups and local authorities. The extended family as a social network, the school and the church play an important role for Romanian parents regarding help-seeking behaviours and responses to ill health. In this study, Scottish and Romanian mothers stated that they were not interested in gaining more experience and expertise when dealing with children diagnosed with ADHD. More importantly, with the belief that care is best carried out in the home by providers, linked to limited traditions of accessing services, many of the Scottish and Romanian mothers chose not to use available formal services like support groups or training programmes. Since parents serve as a liaison between teacher and health professionals, they experienced saturation and, as a consequence, any strategy for improving their parental skills was regarded as worthless. Parents' support groups also

raised controversaries among participants from both countries. These resources were perceived as a waste of time, and so many mothers decided that there was no point in getting involved or actively taking part in these types of activities. Sharing their stories or asking for assistance from a person outside the family was seen as unnecessarily burdening others who would be incapable of understanding their situation. More specifically, mothers expressed great negative emotional intensity and often complained that they didn't have the time to attend support groups or claimed that these networks often unhelpfully sensationalise ADHD.

One explanation for these results was offered by Stewart et al., (2006) who ascertained that formal health and social support services might be rare in both countries making it less likely that mothers will seek out these programmes. Although for many families world-wide globalisation resulted in greater access to resources and opportunities and led to progress in their lives, Scottish and Romanian mothers seemed to reject the benefits of globalisation and considered themselves to be victims of unfair medical and educational systems. Mothers in this study were faced with serious dilemmas around the notion of diagnosis and the treatment process, access to services or lack of employment opportunities. According to Anguiano and Trask (2011), decisions about these issues were not only tied to economic concerns but were also influenced by ideoscapes related to the conceptualisations of family roles, duties, and obligations, which seemed to be based on culture and setting. In the context of ADHD globalisation, mothers lacked certainty about which choices and paths would be best for them.

7.3. Research question 4: To what extent do significant differences in attitude and knowledge exist among the Sccotish and Romanian samples of parents, teachers and support staff?

7.3.1. Limited understanding of the treatment of ADHD within the Romanian sample of teachers, support staff and parents

One of the most telling results of the present study was that Romanian mothers, teachers and support staff had a limited understanding of ADHD treatment. The results obtained from the questionnaire, along with the semi-structured interviews, reflected that the incongruencies in the literature may account for the ambivalence reflected in responses to questions about treatment that were split between expressions of the medical and the social view of ADHD. Mothers' and teachers' knowledge about the treatment of ADHD was shaped by individual and organisational practices, susceptible to imaginings and discourses, and formal and informal politics and public debate. In this context, minorities like ADHD became the place for resisting and taking control or passively accepting the medicalised objectifications of body and behaviour. This might explain why mothers, teachers and support staff made use of various scapes within their discourse which position them as proponents of either the medical or the social conceptualisation of ADHD. Therefore, in order to better understand how the ADHD treatment was perceived, we need to take into account the person's vision of his/her possible self as shaped by the financescapes, global technoscapes, ideoscapes and media exposure (Appadurai, 1996).

Ideoscapes are constructed with the consideration of the development and movement of mediascapes, technoscapes or financescapes. For Romanian mothers, teachers

and support staff, it is important to consider the ideoscapes or ideological conditions in which they were situated, how long they were exposed to them, how they dealt with such exposure and what their expressed values and desires were. Ideoscapes were powerful in shaping the dominant discourses around medications and supplying reasons for treatment adherence or refusal. For instance, the constructive landscapes of aspirations and expectations about "normal" behaviour changed dramatically, explaining the cultural differences in frameworks for making sense of treatment.

Cultural variations in the understanding of treatment could also be attributed to the differential salience of deviance frameworks, which might be grounded in culturally ideological conceptions of mothers and teachers. Just as there is cultural variation in the way "normal", everyday behaviour is explained, this study showed corresponding differences in descriptions of treatment. In the Scottish cultural landscape, mothers, teachers and support staff were likely to locate ADHD within the social model, maintain scepticism towards the diagnosis, resist notions of treatment and provide alternative solutions. Romanian participants were more restricted to the medicalised interventions, conceptualising ADHD as an abnormality as something that the body has or displays. This ideological rhetoric seeped into mothers' and teachers' awareness and framed discussion about the benefits of medication and the right to treatment. They often used minimisation arguments by strategically equating the socially acceptable, harmless and legal pain killers with amphetamines prescribed for ADHD.

Contemporary children in Romanian are no longer simply too lively. They are now suffering from ADHD and require treatment. As the change in the marketing of the drugs is symptomatic of wider changes in economy, psychostimulants become the trendy remedy

that normalises behaviour. The results might be explained by the contrasting broader patterns of teaching and care in Romania. It is therefore possible that treatment of ADHD was an issue that Romanian policy makers considered to be irrelevant and therefore offered limited coverage of these points during the programmes offered for parents' and teacher' training. It is thus plausible that mothers, teachers and support staff might have dismissed the importance of having information about treatment procedures as a result of differing cultural practices. In terms of financescapes, the emergence of ADHD as the disability of the 21st century (Tait, 2006), raised significant questions about mothers' and teachers' financial wherewithal to access services and ask for help. Misunderstandings among Romanian participants might be explained by the impossibility of access and consequently a lack of information about their children's treatment. The paradox was that many researchers claimed that a diagnosis of ADHD should be a catalyst for providing services and support not previously offered to the child. But what happens when services are provided but they cannot be accessed? Competing concerns and needs like low paid jobs, high bills, many dependents, personal and institutional discrimination and the uncertainty about the future led to ADHD being ranked low on the worry list. Lack of money for travelling and time constraints on professional visits made it unlikely that information about ADHD would be provided through efficient channels. These repercussions, which followed a trend existing in the global economy, illustrated the dramatic effect that financescapes could have on the lives of mothers and teachers. Evidence discussed above suggested that ADHD might be more associated with social and economic disadvantage in Romania than in Scotland.

According to Janes and Corbett (2009), the global technoscape as it pertains to ADHD was comprised of an inextricable mix of medicines, medical devices and medical procedures that together constitute what is known as science. The rise and dominance of biology, medicine, psychiatry or pharmaceutical innovation led Romanian mothers and teachers to believe that ADHD could be cured and to prefer the purely medicalised approach to its treatment. Their narratives and the questionnaire answers reinforced the fact, that in Romania, ADHD is still a highly medicalised phenomenon that, thanks to scientific advances, is now able to be correctly diagnosed and treated (Barkley, 2005). Furthermore, with the advance of technology and science, we have now entered into an altogether new conceptualisation of childhood behaviour where the diagnosis is nothing more than a result of the configuration of both high and low and both mechanical and informational technologies. In this globalised context, the commercialisation and commodification of childhood has determined an increase in consumer goods targeted at children and the creation of new commercial opportunities in childhood. For instance, although Ritalin is rarely used in Romania after an epidemic of reported abuse cases, short term efficacy and multiple side effects, other amphetamine-like drugs are still vigorously pushed by pharmaceutical companies. Building on the work of Appadurai and Kopytoff (1986), Oldani (2004) described how peoples' preferences for certain treatments could be influenced by increasingly violent campaigns which promote the production, marketing, prescription, distribution, purchasing, consumption and efficacy of drugs. This explains why participants from the Romanian sample spoke about their struggle to reconcile the medication consumption as either targeting real psychiatric concerns or as the target of a carefully constructed pharmaceutical marketing campaign. Furthermore, mediascapes

represented an important factor in the formation and maintenance of mothers' and teachers' conceptualisation of ADHD treatment. Exposure to the media influenced treatment preferences and expanded each other's ability to imagine new possibilities through the large and complex repertoire of images and narratives (Appadurai, 1996). Indeed, a closer look at the interview transcripts reflected the key role that media played in influencing the way participants looked at ADHD and perpetuated stereotypes of treatment through its portrayals of characters. Very often, mothers, teachers and support staff got stuck into these different mediascapes and embodied their transmitted metaphors. As Ciota and Van Hoveb (2011) argued, in a media-influenced society such as Romania, the media assumed the role of informing the public and of opinion shaper. Indeed, the way in which ADHD was portrayed in the Romanian media exerted an enormous impact on mothers' and teachers' conceptualisation of ADHD treatment. Information about ADHD is everywhere in the newspapers, primetime television commercials, radio spots, public transportation kiosks, billboards, movie dialogues, the internet or daily conversations. Moreover, Romania is recently facing extensive advertising campaigns from the pharmaceutical companies in order to promote Methylphenidate (Ritalin) as a treatment option. According to Mintzes et al., (2002), by promoting a discourse that creates new diagnoses and then reports that these are underdiagnosed and undertreated, Romania has reached the age of "an ill for every pill" (p. 113). As Rubin (2004) has also argued, in a culture that that turns both to superheroes and science, what could be a more fitting reminder of the power of advertising than bombardment with metaphors, images and promises of a better standard of living within quick reach.

7.3.2. Inclusion of children diagnosed with ADHD in mainstream education

7.3.2.1. Attitudes towards inclusion within the sample of Scottish mothers

The quantitative and qualitative data collected in this study showed interesting differences related to mothers' attitudes towards inclusion in the two countries. These results are in line with Gliga's and Popa's (2010) study, which showed that Romanian parents of children with disabilities were in favour of inclusive education and have a deep understanding and knowledge of terminology and specific legislation. In contradiction to the Romanian sample, several Scottish mothers were uneasy about the inclusion of children diagnosed with ADHD in mainstream classrooms and considered that colleagues and friends need to be protected from anyone who is diagnosed with ADHD. Some of the mothers emphasized the need for special provision in order to accommodate and teach children diagnosed with ADHD whereas others prioritised the subject/community of practice and foregrounded how society and schools created the barriers to learning and participation. In other words, even when inclusion was accepted, it became a discriminatory process since special adjustments were required. Appadurai's model facilitated again the exploration of diverse flows along the ideoscapes, ethnoscapes, financescapes and technoscapes. My concern was not so much directed towards children diagnosed with ADHD as a marginalised group or condition, but more on various scapes that could create the diagnosis itself. However, the usefulness of the inclusion/exclusion debate was not discarded. Rather, as Labonte (2004) commented, it is an old dialectic, one that never fully resolves but remains at best a grapple-able task.

Mothers engaged with different ideoscapes which influenced their views on inclusion. Policies and practices at the levels of visions and values, management and organisation, learning processes or proffered pedagogies are changing quite fundamentally the character and fabric of mothers' attitudes. What is now called hyper behaviour was in the past attributed to exuberant and creative people in a wide range of fields. Highly desirable qualities like pushing the limits of everything and doing it all with an intense level of energy focused totally on the future are now labelled as defiant and leading to exclusion. On the other hand, as Appadurai (2001) noted, "minorities are the major site for displacing the anxieties of many states about their own minority or marginality (real or imagined) in a world of a few mega states, of unruly economic flows and compromised sovereignties" (p. 6). Capitalising on this statement, Appadurai's description of ethnoscapes as being the landscape of persons who constitute the shifting world in which we live could be related to notions about the inclusion or exclusion of children diagnosed with ADHD in the mainstream. Indeed, the fact that the diagnosis of ADHD is spreading through this fast-paced, post-modern world, cannot be neglected. Notions about inclusion and exclusion appear to affect the politics of and between nations to an unprecedented degree. In this environment, mothers from the Sccotish sample were questioning belonging to these ethnoscapes by revealing a chaos of ideas and feelings. They generated new social configurations in which children diagnosed with ADHD were not integrated in the mainstream education and fostered new dynamics of deterritorialisation and exclusion.

In this new age of accountability measures, a new question became significant: *What is the financial cost of ADHD to Scottish mothers?* Interestingly, flows of financescapes were observed at both individual and global level. Firstly, the fact that

schools are not receiving funding support for children diagnosed with ADHD was seen by mothers as a barrier to achieving the benchmarks and to being accepted as equals. Secondly, financescapes were identified not only at the level of the individual mothers, but also at a more general level of family economics. Mothers described how the care of children diagnosed with ADHD imposed on their families direct costs, in the form of special medical care, therapeutic and educational services, transportation or other rehabilitative or restorative services. As Lukemeyer, Meyers, & Smeeding (2000) also ascertained, the expensive private costs of ADHD constituted a particularly heavy burden for these families. Furthermore, Scottish mothers complained about the indirect costs of ADHD resulting from the loss of earnings due to increases in the extent and intensity of care giving responsibilities. When asked directly, several mothers indicated that caring for a child diagnosed with ADHD made it difficult to have a job, which consequently led to the absence of any form of social life. For many participants, these children were too expensive to look after. Children were perceived as undesirable and became a burden, a stress and a drain.

Nevertheless, the new technological possibilities transformed the conditions in which mothers experienced, negotiated and challenged the space in which to raise their children. The physical arrangement of the class, lack of advanced equipment or inadequate teaching materials, were all perceived as barriers towards inclusion. However, in the past these technoscapes were considered deeply embedded and immovable. Changes in the world's social, cultural, economic, and technological forces are now affecting individuals' attitudes precisely because they influence how people see themselves, others, the global

world and also their local setting. Such heavy reliance on specialised techniques reflected one of the central concerns of our era: the achievement of a perfect behaviour utopia.

In short, according to Bibeau (1997), globalisation and the corporatisation of the health care industry in its various organisational forms (e.g. de-institutionalisation, privatisation, evidence-based medicine) have radically altered mothers' attitudes and practices. The required parental skills change over each generation, but the challenges families are facing today are different and more complex due to the pace of change. In these fundamentally troubled and troubling times, it was therefore hardly surprising that Scottish mothers had negative attitudes towards inclusion and produced the concept of otherness. Since technologies are now transported on a global scale, ADHD could be conceptualised as a victim of the globalisation process.

7.3.2.2. Attitudes towards inclusion within the sample of Romanian teachers and support staff

The findings of this study indicate a spread of opinion about inclusion between and within the sample of parents and teachers from the two different cultural contexts. Romanian teachers and support staff believed in the benefits of special education whereas Romanian parents were more supportive of inclusion in mainstream classrooms. On the other hand, Scottish teachers agreed that students diagnosed with ADHD can learn successfully in the mainstream classrooms whereas parents considered that their children would be taught more effectively in a special setting. Indeed, as Pearson (2009) ascertained, the co-existence of multiple understandings of inclusive education in society is inevitable but could also be framed as a potentially rich source of learning. Although initially the

results might point to lack of collaboration between parents and educators, these attitudinal patterns need to be further explored within the broader societal emphasis on inclusion. Indeed, many Romanian primary school teachers and support staff were uncertain of, or disagreed with the benefits of inclusion of children diagnosed with ADHD in mainstream education. An interesting aspect revealed during the interview was that, even when teachers believed that children diagnosed with ADHD should be taught in mainstream classrooms, they stressed that their educational needs should be addressed differently from what they called "normal children". The interviews also revealed that teachers and support staff considered that children diagnosed with ADHD are plagued with intellectual deficits, using adjectives like handicapped or mentally retarded. Indeed, it seems that teachers are operating within the developmental perspective of their dominant culture. The structure of the educational system itself is a consequence of all the events in which they played a role in determining, and of which they are themselves a result (Willis & Rappleye, 2011).

The first conclusion that can be drawn is that, in Romania, the implementation of inclusion policies is slow, not well communicated and has no impact on the teachers' practice. However, this underlying assumption should be challenged because very often the broader social milieu escapes scrutiny. Therefore, instead of criticising the broader social policy, a question should be asked about what it means for a teacher to provide inclusive education in Romania. Indeed, there are specific ideological elements which influenced the formation of teachers' attitudes towards inclusion in Romania: political regime, transition characteristics, and changes in social policies, the fast evolution and decline of the national economy, changes in the education system or the process of globalisation. The ideoscapes of the Communist times had one of the most significant impacts on teachers' frames of

mind, attitudes and practical outcomes. Unfortunately, there are few accounts and no systematic studies of Romanians' perceptions of the concept of disability and of children diagnosed with emotional and behavioural disorders either before or after the fall of the Communist government in 1989. According to Phillips (2006), perceptions of minorities, such as children with a clinical diagnosis, stemmed from ideals communicated by the Communist platform, where teaching was mostly subject centered. Students who were identified as having a disability, whether physical or mental, were largely ignored or treated with contempt. The special education institutions were situated outside the residential areas and the number of children with additional support needs was not publicly disclosed. The government's attitude was that such individuals could not become productive members of the socialist society, and as a result they were marginalised and excluded. Additional support needs were not considered important in Communist-style schools, even to the extent that the Communist leaders ended programmes that would train teachers to work with these minority children.

The breakdown of this closed, inflexible Communism regime at the beginning of the 1990s came without warning. Teachers were not prepared to deal with changes in corporate governance. Since changes in school templates, organisational practices and academic behaviours spread across the world with accelerating speed, the transitions to democracy and to the market system were accompanied by some difficult situations for teachers. Many of the school teachers were now expected to make do, and perform with what they had and to do the best they could under the most difficult circumstances. Furthermore, there was an increase in training requirements so that teachers could meet the needs of the changing labour market. Third, the international opening of the economy

effectively raised relative demand, putting upward pressure on skill differentials to bring Romania in line with neighbouring countries. As Sato (2004) concluded about Japanese teachers, due to the current educational changes, Romanian teachers and support staff have felt the pressure to comply with inclusive programming against their own personal beliefs. But this is not what inclusion is about. Rather, it is about "developing critical thinking and reconstructing the vision" (Avramidis, Bayliss, & Burder, 2000, p. 201).

Without drawing definitive conclusions, it could be argued that the disruptions of this transition might have resulted in a declining, rather than improving, quality of education. The loss of intellectual resources represented one of the greatest threats to developing supportive attitudes towards inclusion. The process is called the brain drain (Tascu, Noftsinger, & Bowers, 2002) characterised by the fact that very few students are interested in becoming teachers and young and bright teachers decide to go and work abroad. Having lost control of what constitutes an appropriate understanding of professional values, knowledge and practice, teachers are now looking for a more supportive state than their native one. The teaching profession is suffering from loss of status and is marred by a rise in the number of problems, which points to a deprofessionalising trend (Klaassen & Maslovaty, 2010).

Nevertheless, technologies that were once considered deeply embedded and immovable are now simultaneously transported on a global scale. Overcrowded classrooms, shortages of teaching materials and non-behavioural teaching methodologies, lack of access to up-to-date research are other barriers towards inclusion that teachers confront in Romania. The absence of these appropriate resources contributes to the growth of inequalities, access to education and equality of chances. Financescapes also flourished

in the Romanian teaching environment. In the last years, the major barrier towards a positive inclusion view seemed to be a lack of social status, the downgrading of the teaching profession, and the absence of motivation for this career, all emphasised by low salaries. Potolea and Ciolan (2003) draw attention to the fact that, in Romania, the salaries of teachers are below the national average. Those of new teachers are very close to the lowest salaries paid in Romania and many teachers cannot afford a decent standard of living.

> The declining conditions and low salaries are discouraging new recruits to the profession, creating shortages and threatening to diminish the quality of education at a time when the need for new knowledge and skills is growing dramatically (Ivan et al., 2001, p. 103).

Indeed, low salaries diminished teachers' incentives for working in difficult conditions, especially with difficult students in substandard schools. As a result, children diagnosed with ADHD are more likely to become one of the groups affected negatively by increasing educational inequality. An increase in teacher burnout might lead educators to perceive these children as a burden for the entire educational system. This category of children is expensive to teach, so the easier choice is to exclude them by labelling the students as irresponsible and undisciplined, and to treat them with pessimism and mistrust.

7.3.3. Willingness to get involved

7.3.3.1. Willingness to get involved within the Scottish sample of teachers and support staff

Similar to results reported in previous literature, Scottish teachers and support staff reported having little training about ADHD but more importantly they were not even keen to get involved in any activities aimed at enhancing their teaching competencies. Their attitudes included a lack of interest in gaining experience and expertise with children diagnosed with ADHD. While Romanian teachers complained about the inadequacies of their educational system, the divergent attitudes recorded within the Scottish sample may have stemmed from their lack of confidence in the way the medical system is operating in their country. Although Scottish teachers and support staff considered the support of the child and adolescent psychiatrist or paediatrician to be the most beneficial, they criticised at the same time the helpfulness and impact of such support. At this point, the dynamics of the ADHD diagnosis cannot be understood without first ascertaining the importance of the cultural discourse and power hierarchies that exist in contemporary Scottish society. The theoretical framework of Appadurai's (1996) scapes or global flows of people, images, ideas and technologies was used again in order to understand participants' narratives. Their discourses provided rich information about the issues of culture, globalisation, and the multi-positioned nature of teachers in Scotland.

Firstly, teachers' reluctance towards engaging in training and further professional development was influenced by their lack of confidence in the current medical system. But what values are promoted by the medical field? How does the educational system

embody these values and establish the institutions through which those values are to be understood and expressed? One answer is offered by Radcliffe and Timimi (2002) who observed that child psychiatry in the United Kingdom does appear to have re-invented itself in the last 10 years. The current professional discourse is now convinced that there are more personal rewards by it adopting a more medicalised American style approach. ADHD helped construct the field of neuro-developmental psychiatry, which teachers and support staff viewed as either real, or contested as being an invention. Involuntarily, teachers became part of a large and complex process of flows within the global medical industry. Since they were dealing with children with a clinical diagnosis, participants' identities were shaped by the needs and ideologies of the medical sector in two ways. On the one hand, some teachers incorporated various medical ideologies and became franchisees in the sickness marketplace (Phillips, 2006). On the other hand, many Scottish teachers and support staff criticised the practices of medical assessment for ADHD, implied medical failings and had knowledge claims oriented to accounts of over diagnosis. Several mentioned long wait times when calling health services, incomprehensible medical language, the lack of doctors' presence in the school meetings and the minimal involvement of schools and teachers in inter-agency practices. These pragmatic differences are related to the way in which medical practitioners use professional discourses that might be subject to various meanings that influence the way in which teachers understand and make sense of their messages.

Furthermore, the medical system is nowadays characterised by a bewildering proliferation of technologies designed with the aim of making people go through their activities faster, enhancing performance with a pill. According to Timmermans and Berg (2003), medicine forms an archaeology of layer upon layer of technoscapes, from the most mundane band-aids and pencils to sophisticated machines such as Magnetic Resonance Imaging and artificial hearts, from virtually neutral infusion pumps to highly symbolic procedures and devices such as genetic tests. Illustrating the slogan "personal is political", DeGrandpre (cited in Cohen, 2006) linked these rapid technological changes to individual's internal states. He believed that as technologies change faster, so does the rhythm of the consciousness. It is thus possible that the cognitive and emotional adaptation to quickening change produced an unexpected effect on teachers' and support staff's availability, desires and frustration. Teachers had to shift their position on an almost daily basis, as they negotiated the cultural, technical and economic flows of the scapes. They have entered Featherstone's (1990) third culture of new professionals where they are forced to develop new roles and responsibilities. Through the critical moments they reported, several practitioners developed their own philosophies and new methodologies of teaching children with a diagnosis of ADHD. Indeed, in this new globalised world, "the new teacher is constantly on stage and urgently needs to develop a performing self" (Featherstone, 1990, p. 101).

Teachers and support staff might feel that they cannot cope with the change, become overwhelmed and as a consequence refuse to get involved. One good example was the development of the new behaviour rating scales (e.g. Conners' Teachers' Rating Scale) which, although considered as a key part of the diagnostic process and presented as an objective tool, ended up being highly criticised by the Scottish teachers. Almost all participants complained about having to complete these inadequate rating scales which were judged as being culturally biased and standardised by a relative norm group against which all future test takers will be measured. Indeed, if trained professionals cannot agree on how to rate behaviours relative to some sort of agreed norm, it is not surprising that teachers and support staff had different thresholds.

7.3.3.2. Willingness to get involved within the Romanian sample of teachers and support staff

Although they frequently complained about the difficulties experienced within the current educational system, teachers and support staff in the Romanian sample were willing to engage in training and activities designed for children with ADHD. While Scottish educators worried about the direction the medical system is going, Romanian teachers expressed frustration about the structures of schools, government policies and work conditions that did not allow them to perform well. Following Appadurai's theory, teachers' attitudes are driven by the increasingly complex relationships of educational ideologies, money flows, political sensibilities and the availability of labour. Examples of teacher-location in various ideoscapes, financescapes and technoscapes were frequent

within their narratives. Maybe one of the most important findings was related to the different ideologies of science teaching in Romania and the culturally specific values promoted by the educational system in comparison with the Scottish system. All these cultural differences affected teachers' ability to understand, manage and cope with ADHD. As could be seen, each teacher brought his/her own perspectives and values to the educational system, and these beliefs and practices differed from those identified within Scottish culture. Romanian teachers had culturally specific ideas about how teaching should be delivered, expectations about training and professional development and judgements related to the system's efficiency.

In line with Appadurai's notion of ideoscape, Romania was greatly affected by globalisation and its education policies compared with those in developed countries were negatively influenced by it. The process of teaching in Romania was frustrating, unrewarding and intolerably difficult. Supporting Johnston's (1997) findings with Polish teachers, data from this study reflected that teaching was anything but a life-long career in Romania. Teachers did not normally teach in the long term, short-term employment was common and many teachers left the field long before middle age, unsustained by either an institutional career structure or an inefficient system. In the absence of professional ethos and identity, teaching was defined as being an unstable, unrewarding and impermanent occupation.

Furthermore, the decision to become a teacher was interpreted in the context of the various financescapes encountered by professionals. A considerable number of teachers and support staff described the way in which they were affected by the present financial flows. Low salaries along with the massive increase in enrollments were a signal that educators

lacked importance and professional value, making teaching a very unattractive career choice. Many Romanian teachers in the state sector had to double as private instructors, thereby deflating labour issues. Comparisons between Romanian defects and Europe's qualities were also constant throughout participants' talk. As Johnson and Birkeland (2002) have highlighted, recent graduates are not motivated to choose teaching when there are so many opportunities offering high pay and status, comfortable, well-equipped work settings, continuous training and opportunities for rapid career advancement. This might be the reason why the number of teaching staff has dramatically generally decreased in the last few years especially in rural areas (The National Institute for Statistics, Romania, 2011).

Within the Romanian sample, support staff were more keen than class teachers to undertake further training and qualifications relevant to their present post. Since opportunities for training were sporadic and inadequate in Romania, support staff showed more interest in developing their career further than did the primary school teachers. This was a very special element of the Romanian educational system since the support staff do not have a teaching background and they usually come from the same community as the children. Therefore, while teachers' motivation might deteriorate over time, support staff could develop an obvious enthusiasm and love of their work and a high level of self-esteem and personal gratification from doing what they consider a worthwhile and important job. They are passionate, energetic, enthusiastic, and flexible learners who love and are dedicated to their jobs. As schools become more inclusive, the role of the support staff is to help with the administrative tasks, serve as a role model and liaise between family and the school. In almost every Romanian primary school, there is an additional staff member in each class who assists students diagnosed with ADHD, make efforts to get to know the

students better, become more empathetic towards them and often feel rewarded by seeing students develop and learn.

While class teachers are more focused on academic achievement, support staff are more orientated towards creating a caring and warm ambience within the classroom. Because they spend more time with the children and have fewer responsibilities, they feel much more comfortable and relaxed with the level of intimate knowledge of the children and in time became very positive and supportive. Both children and parents treat the support staff as allies because they came from the community, spoke their own language and listened to their opinions. Indeed, "the support staff could bring to the classroom their experiences, knowledge and understanding of school practices, local language and culture, parental insight, the child's perspective, and a confidante's empathy" (Doherty, 2004, p. 119).

Nevertheless, in any type of training, the success and quality of education could be achieved only if the necessary resources were provided. The paradox was that, although teachers and support staff were positive about getting involved in professional development, there were very few opportunities related to training about ADHD in Romania. In this sense, Crawford and Foster (2001) compared the educational developments in the United Kingdom and Romania since 1989 and concluded that the training expertise was not yet in place in Romania, appropriate in-service training courses, seminars, and materials had yet to be developed, modern media was in many places not available and the technological equipment in schools, in-service facilities and other educational institutions were inadequate.

Teachers' need for training raised another issue in relation to the transformation of schools into a major training site for medical practitioners and pharmaceutical companies to push forward their conceptualisation of students' emotional and behavioural difficulties. A prime example was provided by the 2011 initiative of the Romanian Ministry of Education, The National Center of Mental Health and the pharmaceutical manufacturer Eli Lilly Romania who developed a partnership in order to raise teachers' awareness about the causes and treatment of ADHD. Implemented in 14 cities throughout the country, the project had the main aim of making educators understand that every child has the right to medical treatment. The way in which medical ideologies are imposed on the educational system was reflected by the public relations director of Eli Lilly (Romania), the 10th largest pharmaceutical company in the world:

> Fortunately for teachers, ADHD is one of the most treatable disorders within the child psychiatry field. We urgently need to raise awareness in relation to the disorder called ADHD because we possess scientific proofs that without treatment, this disorder could have extremely negative consequences for the individual, family and the whole society (Dr Popescu, Eli Lilly Romania, in press).

8. Conclusions and final remarks

8.1. Reflections on the limitations of the study

The journey of every researcher is unique to each individual. As with many educational researchers, the path of my research journey was one of discovery and development. As a student within an education department who conducted her research in both hospital and school settings, I would add that my path was one of confusion, complications and complexity. I did not anticipate that this journey was going to be easy and straightforward. Even at the early stage in the process, I encountered ethical and methodological issues and professional and personal conflicts. A lot of debates and challenges surrounded parents' and teachers' conceptualisation of ADHD. It was near impossible to explore all the dimensions of the phenomenon. I had to learn to be patient in understanding that my design was not written in stone and the beauty of my study was the ability to change things, including my very own research process.

Despite the limitations, the information gained in this study contributed to current understanding and awareness of the experiences parents and teachers had when coping with a child diagnosed with ADHD. This research originally examined some of the most important aspects and tried to offer some pertinent explanations. The results obtained should be regarded as tentative and the issues raised clearly require additional investigation. Upon reflection, these weaknesses were beneficial when defining future areas of research.

8.1.1.Conducting field research in a primary school setting

I found many obstacles in completing my thesis. Many of them were unsolvable and I needed to be flexible with my topic. For instance, my study was initially set up to investigate the triad of teacher-child-parent. The aim of the research was to select a number of children diagnosed with ADHD, establish contacts with their mothers and identify their classroom teachers. However, the problem of access was of greatest significance early in the research when I started to negotiate entry to the educational establishments under consideration. Unfortunately, in Scotland, one local authority refused to take part in the study. I was aware that I was perceived as an intrusion and the gatekeepers did not want a public examination of their private space. I also felt that I was positioned within a set of wider social processes over which I had limited knowledge and little control. In this scenario, I had to refine my research several times and make use of my alternative plans. Due to time constraints, procedural problems and the local authority's refusal to take part, I decided to investigate an overall knowledge and attitudinal pattern, with no relation to any particular child. In this way, my research managed to offer a broader picture of parents', teachers' and support staff's conceptualisation of ADHD in different locations throughout Scotland and Romania. A future study with a smaller number of participants could employ a case study design. Several case studies could be compared by correlating teachers', support staff's and parents' attributions with children's own understanding of their condition.

Even when approval was obtained, the majority of Scottish and Romanian teachers and support staff were not enthusiastic about participating in the study. Overall, they showed a lack of interest in the subject matter and offered brief answers to the interview questions. One explanation might be the fact that recruitment of teachers was mediated through the local authority and the headteachers from each school. Teachers completed the questionnaire at their own convenience and interviews were conducted in the formal school setting. In other words, due to time constraints and accessibility problems, no closer connection could be established with teachers. Longer time to advertise the research to teachers and increase their interest in the ADHD topic might be required. A closer relationship between the researcher and the participants could contribute towards research methodologies that produce more meaningful and rewarding experiences for teachers who might be more likely to participate in future research and potentially use the findings to inform their practice.

8.1.2.Conducting field research in a hospital setting

The process of gaining access through the space of the paediatric clinic was much more simple and straightforward. In the United Kingdom, obtaining ethical approval is overseen by the UK National Health Service (NHS) ethical review and governance system. Key standards of ethics include the need for independent ethical review of relevant research, informed consent, and appropriate use and protection of patient data and confidentiality. I was also required to adequately assess risk and minimise any potential for harm among participants, respect diversity, avoid discrimination, and encourage participants' involvement in the design, dissemination and implementation of research findings. The amount of work that went into preparing the submission was extensive. Producing an application of the quality required to satisfy the NHS committee was a time-consuming, labour intensive and bureaucratic task. Difficulties were encountered mainly because the research ethics system was designed as a mechanism for governing quantitative experimental research and often failed to understand the nature of more complex mixed-methods studies (Pope, 2005). The risks posed by my study, when compared with interventions in randomised controlled trials, were minimal.

The whole process lasted 12 weeks from original submission to final approval, including official meetings to discuss the project and time to make minor amendments to the application form and supporting information. Taking account of the length of time required to prepare, the submission did make for a much lengthier process which I was not aware of in the beginning. However, looking back at this experience, I have to acknowledge that the NHS application process represented an opportunity to better prepare

for my research and to think about best practice, not only in terms of ethics, but in a very in-depth and constructive way. It afforded an invaluable opportunity for reflection and anticipation of any potential problems. Once the ethical approval was granted, I started my field work within two busy paediatric clinics. At the beginning, I was an outsider and a complete observer. Given my desire to understand the culture and practices within this research environment, I tried to develop good relationships with all the staff members. At the same time, I also wanted to avoid the impression that I was evaluating the staff members or the health systems in place. Although everyone was aware that my PhD involved exploring parents' understanding of ADHD, I tried as much as possible to disguise my topic area and to avoid contaminating my results.

As my relationship with the paediatrician, psychologist and nurse developed over the course of the study, I felt that I became more integrated into the team and moved closer to the participant role. I was allowed to tape record the clinical consultations, I exchanged professional opinion and approached the potential participants. I was also allocated a consultation room where I had discussions with the parents and administered my questionnaires. However, in trying to sustain a full organisational membership role and the research perspective simultaneously, I encountered a role conflict and found myself caught in loyalty tugs, behavioural claims and identification dilemmas. For instance, I was frequently introduced to other members of the ADHD team and to patients, as being a psychologist colleague. I was therefore functioning in multiple roles simultaneously. I was a research student from a different country, coming from an education department, with a clinical psychology degree and working in a hospital environment. In order to avoid these misconceptions, I dedicated at least 10 minutes of the appointment time to explain to

parents what my student status was and what my study involved. However, it was precisely my personal biography that allowed me access to information that might not be given so willingly to a differently positioned researcher.

Despite these theoretical and methodological problems, members of staff and parents were both very receptive to taking part in my research. During my practice in the hospital, I was able to create a closer relationship with all my participants who were very enthusiastic about the research topic. Questionnaires and interviews offered me the opportunity to engage parents in emotional conversations about their experiences, challenges and accomplishments. Unconsciously I became a part of their ADHD picture and struggled to maintain the professional boundaries with my participants. However, I was constantly aware that my emotions influenced what I heard and saw and this constellation of feelings affected the way I represented my findings. As Stanley and Wise (2002), point out:

> Whether we like it or not, researchers remain human beings complete with all the usual assembly of feelings, failings, and moods; and all of those things influence how we feel and understand what is going on; our consciousness is always the medium through which the research occurs; there is no method or technique of doing research other than through the medium of the researcher (p. 157).

Due to time constraints, several data sets were discounted. For instance, I recorded each clinical appointment and interviewed a number of children diagnosed with ADHD, paeditricians, nurses and psychologists from both Scottish and Romanian hospitals. A post-doctoral research study could focus on parents, teachers, medical practitioners and children themselves and explore how their attitudes and knowledge about ADHD develop over time.

8.1.3.Researching a medical diagnosis from a non-medical perspective?

My study aimed to investigate the current conceptualisation of ADHD in two different cultural contexts. Employing the medical terminology of *Attention Deficit Hyperactivity Disorder* often implied referring to ADHD as being a disorder. While some might argue that the medical discourse was automatically introduced to participants, I believe that using other synonyms could only add more confusion. Because the research design involved parents, teachers and support staff from two different countries, various knowledge and attitudinal patterns had to be explored in relation to a specific concept that manifested relatively similarly in both settings.

Furthermore, I acknowledged the effect of the medicalised context in which my research was undertaken on the analytical process and the results obtained. ADHD was a context-sensitive diagnosis which was partly studied within a hospital setting. In Scotland, in order to obtain the ethical approval, I was asked to find a local senior doctor (consultant or general practitioner) as the local collaborator for the research in that region. My first encounter with the potential participants was in the paediatric clinic which was also used as

a site for data collection. It was also possible that parents felt pressurised by medical practitioners to respond in a certain way.

However, the rationale, along with the potential benefits of conducting research in a medical setting was clearly outlined. The medical profession cannot be accused of contaminating and attempting to assert medical dominance over my research. In reality, you cannot study a disorder without actually calling it a disorder.

Although the terminology of ADHD was used, participants were informed that a medical definition does not necessarily imply the adherence to the principles that belong to the medical model of disability. Indeed, the results suggested that mothers and teachers had various interpretations of ADHD which reflected the complexities and contradictions of meaning associated with any disability. Irrespective of whether the field work was conducted in schools or hospitals, different conceptualisations of ADHD were either accepted or challenged and interrogated. However, in order to avoid these misunderstandings, further research should consider looking at children without the clinical diagnosis but who might possibly meet the full criteria for ADHD.

8.1.4. Conducting mixed-methods research in an educational and medical setting

Undertaking research in an educational and medical setting through a mixed-methods approach was neither quick nor easy. According to Casey and Murphy (2009), the issues most critical to the integrity of research using mixed-methods design were described as whether an explicit justification for mixing methods was provided, the extent to which the methods selected had the potential to address the research question, the rigour with which the research was conducted and the way in which triangulation was implemented. Instead of interrogating which research paradigm should predominate, I selected my methods and approaches with respect to my underlying research questions. For instance, in order to understand how ADHD was conceptualised by parents and teachers, I designed a self-report questionnaire with the aim of selecting a purposeful sample for a more in-depth examination of their knowledge and attitudes. The quantitative method was used to inform the development of a more qualitative approach, where the most interesting cases were further explored.

The mixed method design was successfully used to portray a broader picture of ADHD reflected in situations located at both ends of the positive and negative spectrum. By combining the breadth of the quantitative data with the depth of the qualitative analysis, various contradictory stories were presented and interpretations of the current situations were offered. A multi-faceted illustration of the ADHD phenomenon was offered, adding insights and understandings impossible to obtain by only one method of enquiry.

8.2. Implications for practice, training and research

8.2.1.Introduction

The findings of this study have significant implications for teachers, school administrators, parents and other stakeholders who are directly and indirectly involved in the lives of children diagnosed with ADHD. Firstly, these will be discussed and related to a number of general implications for practice, training and research pertaining to teachers and parents. Secondly, based on my empirical findings in the preceding sections, the most interesting differences between the Scottish and Romanian samples will offer some specific implications according to each cultural context. The implications in this section are offered as hypotheses for further exploration, and not as settled answers.

8.2.2.Implications for teachers and support staff

8.2.2.1. Local knowledge and local knowing; Treatment of ADHD

The results of this study suggested that there were substantial contradictory views about the treatment of ADHD among primary school teachers from Scotland and Romania. Since teachers played a pivotal role in the recognition, referral and treatment of ADHD, the above findings implied a greater awareness of the potential treatments and interventions for children diagnosed with ADHD. Indeed, knowing the critical factors of treatment and the processes through which they operate could optimise and guide the understanding of the

most effective means of teaching and caring for children. In this sense, it is both effective and highly beneficial for teachers to receive adequate information and opportunities to make informed choices about treatment. But what kind of information do teachers need? Are teachers required to possess a system of theoretical knowledge about ADHD treatment? In order to answer these questions, it is useful to think about two important aspects.

Firstly, the majority of information about treatment is often presented from a bio-medical perspective, within special education coursework contexts and medicalised networks of support. Teachers and support staff could benefit from acquiring more than basic information about the wide range of treatments that currently exists. They could be helped to approach their roles with a change orientation, an orientation that suggests constant reflection, evaluation, and experimentation. They could be encouraged to listen through the filter of their own mind set and use the experience they have to discard some content accordingly. Policy makers in both the educational and medical fields are invited to question how and why teachers become involved in the treatment of children and further to ask how teachers might be helped to critically reflect upon their motivations, role and possible implications of their involvement. These specific questions could elucidate the underlying mechanism behind treatment choices and might represent a step towards the personalisation of care. Favourable outcomes could be obtained if teachers and support staff are provided with more critical knowledge that broadens their perspectives about ADHD, facilitates the understanding of the ambiguities associated with the treatment and helps them to make a better informed choice.

Secondly, teachers' views need to be taken properly into account. Although collaborative approaches are well documented by previous research, much less is known about what helps to facilitate a successful collaboration. Findings from this study suggested that, at the national policy level, a personal commitment to opening lines of communication through active, consistent outreach might represent a way forward that is led by concern with developing leading-edge practice. At the local level, education authorities might consider bringing parents, teachers and medical practitioners together and offering multi-professional help and support. The strategy for collaboration could firstly focus on outlining its basic principles, establishing members' roles within the team and recognising this joint work as a part of every professional's job description. Working closely together could facilitate learning from each other, both about the resources and services that are available to children, but also about approaches to work. With active, consistent outreach efforts, they all can be partners in the education of their children (Jonson, 1999).

Thirdly, although conclusions drawn emphasised the global, complex and multilayered nature of professionals' work within multidisciplinary teams, several culturally specific aspects need to be taken into account. For instance, one result with significant implications was that Romanian sample of teachers and support staff showed a lack of knowledge in relation to ADHD treatment when compared with their Scottish colleagues. These findings might raise the question of how to increase the knowledge about ADHD treatment in this particular cultural setting. Maybe the time has come to develop cultural competence among teachers and offer them culturally-specific information needed to care for their students. Accordingly, in the instrumental and biomedical Romanian context, multi-disciplinary teams could focus more strongly on developing

critical thinking skills in order to understand the ambiguities associated with the treatment of ADHD. A specific suggestion is creating a forum for discussion regarding current treatment approaches within a multi-disciplinary conference. Teachers could bring to the conference a list of questions and information they would like to share and come prepared to listen. This event would represent a great opportunity to express possible worries about treatment, explore options together, and discuss strategies that might help the child.

On the other hand, providing more opportunities for teachers and support staff to read and evaluate empirical academic research could broaden their perspectives and enhance their practice. However, the Romanian government's attempts to make progress towards these goals have been deterred by economic restraints. Currently, the educational and health system is undergoing a chronic restructuring process characterised by deprivation of funds, research literature and equipment. As a consequence, teachers and support staff are missing out on up to date information about medicine, science, and technological aids because libraries cannot afford to buy books, journals or other teaching materials. In this sense, the Romanian government could start thinking about cost effective ways to increase funding to make research studies freely available online and to facilitate access to up to date resources where the different perspectives on ADHD treatment are explained. Another strategy would be to join programmes involved in the publication, distribution, exchange and donation of books, journals, and related materials and to encourage new initiatives that would increase the availability of quality scientific literature. For instance, The International Network for the Availability of Scientific Publications (INASP) works with partners to support global research communication through

innovation, networking and capacity strengthening, focusing on the needs of developing and emerging countries. According to Tates and Meeuwesen (2001), the benefits might take place at an personal level, where the medical practitioner-teacher interaction takes place, as well as on a macro level were negotiations could strive for more effective co-operation and integration of both education and health care policies.

8.2.2.2. *Concepts of exclusion and inclusion: How can teachers become more inclusive?*

An important theme that emerged from this study was related to teachers' and support staff's attitudes towards inclusive education. Assuming that the successful implementation of any inclusive policy is largely dependent on teachers being positive about it, this study showed no evidence of a total inclusion approach. Child related variables, teachers' factors and environmental barriers were mentioned by both Scottish and Romanian teachers, but with different levels of intensity. In this case, the argument could be made that traditionally, mainstream education has deflected attention away from its own limitations and anomalies. All over the world, education systems are facing serious problems with the workability of achieving educational equity, mainly because they fail to address the various ideoscapes, financescapes, mediascapes, ethnoscapes and technoscapes that teachers are experiencing when implementing inclusive mandates in schools. The broader cultural, social and economic complexity of inclusion is often dismissed. It is exactly this lack of precision in rhetoric that could encourage education stakeholders to

reflect upon what it means for a teacher to be able to provide inclusive education. In particular, for practices to be successful, asking how teachers understand the meaning of inclusion, what provisions they need and why empowerment is a vital element of inclusion might prove beneficial to all parties involved.

Reviewing the various conceptualisations of ADHD and what is meant by inclusion are important steps with both practical and policy significance. Therefore, rather that designing interventions presupposing that teachers understand what inclusion is about and what its purpose is, teachers could be initially helped to recognise what teaching in an inclusive setting actually means. The goal and expectation of inclusion could be made explicit, helping teachers to understand why such inclusion is necessary. As Kingston (2006) has commented, in the absence of any coherent framework for guiding teachers, the implementation of inclusive practice could hardly be described as supported by a clear underpinning policy and a shared understanding of the goal of inclusion.

In order to prevent or remove misconceptions, teachers could start to critically reflect on their future inclusive practices during their initial teacher education. As Goodley and Runswick-Cole (2010) argue, rather than developing normative teaching which emphasises competition and narrow notions of achievement, teachers need to think more about creative pedagogies, whilst also being prepared to criticise and test their own assumptions and comfortable practices (Stephen & Brown, 2004).

Teacher education for inclusion could be a course taught by all departments of education that prepare future teachers for the new global reality. Further professional development programmes could also make room for a critical discussion of the concept of inclusion, giving teachers the opportunity to reflect on their attitudes. Reflection could be

possible through many means like using written and video-based cases in order to highlight the issues, concerns, and complexities that surround classroom practice. In addition, offering knowledge about evidence-based inclusion practices that are positive could represent a valuable source of input for teacher education activities. Experienced teachers might help other colleagues to get beyond their own lack of experience and knowledge to explore in greater depth why their realities might be so different. Such activities are more likely to provide the educators with both the vision and skills to operationalise that vision; these are skills that allow them to modify their everyday practice in ways that are ultimately inclusive (Avramidis & Norwich, 2002).

These recommendations are even more important for a considerable number of Romanian teachers and support staff who saw few benefits from the inclusion of children diagnosed with ADHD in mainstream classrooms. In this sense, policy makers could be encouraged to give greater thought to the contributions that scapes make to the wellbeing of teachers, and greater consideration to how policies affect teachers' ability to continue to do so. Socioeconomic conditions, but also the mentality and prejudices of the Romanian majority are external factors with an important impact on teacher education in Romania. For instance, during communism, education in Romania was highly politicised, with the state deciding the specialisations to be promoted. In this context, social science was deemed to be less relevant and several university departments (e.g. psychology and social work) were closed. Traditional approaches reinforced the popular conception that inclusive education was about special children who would prove problematic when reinserted in a mainstream setting. Teachers' mentalities were rooted in communist models of service delivery which endorsed the exportation of student difficulties to other professionals

specially trained to deal with them. In recent years, the Romanian educational system faced a transition from this process of pathologising the differences to a more comprehensive approach to equity and inclusion. The transition from communism to democracy, with its appealing civil liberties, also brought economic insecurities and challenges. Romanian teachers and support staff were called upon to accept changes in policies and practices in order to meet the needs of all students in inclusive classrooms. As changes in school templates, organisational practices and academic behaviours have been occurring with accelerating speed, the new conceptualisation of inclusion has not been fully comprehended.

In the light of these findings, policy makers need to investigate whether Romanian teachers are sufficiently prepared to change their vision and implement new inclusive practices. Furthermore, in order to achieve the right inclusive organisational climate, policy makers must take into account the needs of teachers and consider the specific ideoscapes that assist educators or hinder them from meeting their needs. These two aspects could be included in any initiative aimed at educating and preparing teachers for their careers. On the one hand, universities, educational departments or training institutions could provide various forms of support for teachers such as open discussions, seminars or conferences where the Romanian history of inclusion is presented for debate. Teachers could become accustomed to getting out of their comfort zones to talk about and debate these controversial issues. On the other hand, it might be beneficial for teachers to receive considerable guidance and support to think critically about their inclusive practices in a cultural context and how the flow of scapes influences those practices. Changing Romanian teachers' views about inclusion could not only help them solve immediate problems but

could also support them in the move from a limited to a more complex understanding and knowledge about children diagnosed with ADHD.

Secondly, there are good reasons to suggest a stronger focus on the theoretical understanding of children with disabilities. As Cope and Stephen (2001) have suggested, the relevance of theory needs to be made explicit to future teachers in order for them to use it as a tool for the analysis of their own developing practice. The challenge is to educate in ways that promote and sustain understanding and acceptance of a wide range of disabilities, providing skills to support students with various needs in inclusive classrooms. In terms of Appadurai's (1996) cultural theory, instructors might draw from the readings of the ethnoscapes, technoscapes, mediascapes, ideoscapes and finanscapes to develop a critical understanding of a wide range of needs. There is no scientific evidence that teachers require training on a specific childhood disorder. What they need instead is a supportive environment that helps them to address the multiplicity and situatedness of oppression. No single model of education can make a classroom entirely inclusive. For instance, teachers can modify classroom management strategies to meet the needs of a child diagnosed with ADHD. However, such changes in classroom structure might not help a student diagnosed with a reading disability to learn how to read. As we move towards more inclusive education systems, positive outcomes could be achieved if all the aforementioned information is offered to teachers from the start of their teaching careers. The university courses could offer the knowledge that teachers need to feel comfortable with diverse children and young people with disabilities, providing them with a sense of competence that demystifies the children's situation. In this way, teachers and support staff could acquire both curricular and pedagogical knowledge, along with awareness, flexibility and

critical thinking. Attending these university courses might subsequently reflect their willingness to experience new approaches and challenge the current educational practices. By incorporating a disability studies module into teacher education and preparation programmes, teachers and support staff could become better prepared to create an educational context in which ADHD is no longer a site of oppression. The module could provide a comprehensive insight into the changing and challenging nature of ADHD theory, policy and research, giving educators theknowledge and skills to meet these challenges.

Thirdly, a major push for any educational system could be centred on teacher empowerment. Schools could maximise teachers' participation by providing appropriate resources and by including all teachers in decision-making concerning classroom policies, student instructional planning, and even the training programmes offered. This aspect is particularly critical for general education teachers, who need a voice in decisions that will affect their classrooms. Offering enough resources and valuing teaching and teaching quality are issues that need to be addressed at the school level within a whole-school policy and at the local authorities' level through a reorganisation of the support services. How the education system values teachers remains a powerful test of the gap which exists between inclusive rhetoric and inclusion in practice.

These inclusion principles are particularly relevant for the Romanian context, where the multidimensional notion of empowerment and the significance of the personal and professional context in which teachers work were often overlooked. Before blaming teachers for their unsupportive attitudes, questions need to be asked about the various scapes that influence the status of the teaching profession in Romania. For instance, data

from this study suggested that increasing teachers' salaries and improving their professional status might offer one effective way of enhancing the attitudinal patterns towards inclusion. However, considering that the present financial crisis imposed a 25 % cut in public sector salaries, these goals might be difficult to achieve in the short term. The real need is for radical reform of the public sector to attract young teachers, while removing the dead wood which has clung to posts during economic transition, in effect impeding the whole process (Fretwell & Wheeler, 2000). Furthermore, policy makers could at least try to increase teachers' leadership and build a career ladder into teaching. This aspect can be realised by offering better working conditions, providing more administrative support and facilitating their participation in the negotiations and coordination of school affairs. For instance, a substantial increase in resource commitments may be necessary for Romanian classroom teachers to feel more positive about inclusionary practices. Access to resources and support might increase teachers' perception that they can have an impact on the educational outcomes of students diagnosed with ADHD. Furthermore, up to date teaching materials could be supplemented and designed to promote both teachers' and students' learning. Workload might also be considered on a classroom-by-classroom basis, taking into account class size, the number of children with special needs in relation to the class size, and the type and severity of the needs of students in the mainstream setting.

8.2.2.3. Willingness to get involved: How can teachers move their practice towards active involvment?

Teachers' willingness to pursue additional training and experience was a key element in this research. In general, the results showed that teachers' and support staff's practices of involvement varied from one cultural context to another and even within the same sample. Whereas in Scotland teachers offered explanations related to the inadequacies of the medical system, in Romania unsupportive educational practices were often mentioned. Whether the cause resided within the educational or medical system, most people would agree that any support initiative must take into consideration teachers' own conceptualisation of ADHD, to determine whether training is needed and, if so, to specify what training should be provided. In this sense, this study could be utilised as a needs analysis that has examined the existing needs for training within several Scottish and Romanian primary schools.

Overall, collaborative partnerships seemed to be isolated and sporadic in both countries while co-operation between professionals was weak. In Scotland collaborative efforts were more often organised, but their focus was mostly on the assessment of the behavioural symptoms. However, this is not what collaboration should be about. In the field of ADHD, collaboration could have far greater potential if stakeholders in both medical and educational fields engaged more in questioning the meaning of multidisciplinary collaboration and its associated agendas. Before setting out on designing policies, policy-makers could start by clarifying the value of teamwork between professionals, on what basis it is constructed and what expertise teachers could bring to a

multi-disciplinary team. These questions might be difficult to explore, but answering them will open doors to the future involvment of teachers in the ADHD diagnosis process.

A joint model of work would invite teachers and health professionals to bring their personal skills and experience to the table as well as resources and philosophies. Mutual involvment, empathy and empowerment are essential in the development of a successful partnership. This two-way dynamic process might then enhance the strength of each individual and ultimately create strength in the larger community. For instance, in order to share ideas and learn from each other, the observations, assessment, recommendations and monitoring undertaken by teachers needs to be made valid in a multidisciplinary context. One way of achieving this goal is to invite classroom teachers to attend the initial clinical consultation where the potential diagnosis is considered. Those visits could include a discussion about students' academic history, issues relating to mental health assessments, access to services and possible treatments.

This study showed that both samples of Scottish and Romanian teachers required more than medicalised knowledge about pills and interventions. In the light of these findings, it seems important to ask ourselves what information is offered to teachers about their involvement in the diagnosis process and what abilities they need to bring about positive outcomes for their students. In order to create a positive collaboration and knowledge sharing environment, teachers could be empowered to understand the complexities of the ADHD diagnosis and what value teachers, school districts, individual schools or education policies could add.

Changing teachers' and support staff's perspectives about training is an important matter in Scotland where professionals reported that they were not keen to get involved in

any activities aimed at enhancing their competencies. One reason for these findings was the lack of confidence in the current health care system. Overall, their recommendations indicated that they wanted more support from medical practitioners and desired some change in the way that health services are structured and commissioned. If a network of multidisciplinary teams is to be a reality, those directly involved in ADHD diagnosis must be given the necessary information about the instruments used for assessment. For instance, the Conners' Rating Scale is simply a tool, and like any tool it is more applicable for some tasks than for others and can be misused and abused. Although the exposure to various assessments revealed some positive effects, such as sensitising teachers to the needs of students diagnosed with ADHD, this study posed questions about the additional effect of creating a conventional wisdom that rating scales are diagnostic of ADHD. Perhaps the co-operation between professionals could be enhanced by using effective dialogue techniques alongside the formal testing procedures. Using active listening could encourage teachers and medical practitioners to open up and answer questions as well as encouraging them to take part in conversations.

Nevertheless, these concerns about the potentially disempowering consequences of teaching are intended to highlight the need to rethink and rework conceptions of empowerment in the contemporary context of mainstream education and teacher education in particular. According to Stephen and Brown (2004), the emphasis needs to move from the identification and plugging of deficits in current practice when compared to some ideal and generalised formulation. In this regard, there might be a compelling rationale to include training in collaboration and team work as an integral component of pre-service and in-service programmes for all teachers. Undergraduate teacher training could offer experience

in multi or inter-disciplinary teamwork where the constituent members are across the health and education sectors. The next stage of professional development could focus on more specific issues related to the agencies and professionals involved, along with targeted learner needs.

Providing opportunities for training is particularly important in the Romanian context, where teachers and support staff seemed to be more willing to get involved in developing their skills. While in Scotland teachers are offered a wide range of opportunities designed to build their professional capacity, in Romania these opportunities are often quite restricted. Teachers had to improve their teaching on their own, learning from trial and error, and individually sought the required professional development. While expected to carry a full educational load, some teachers taught disciplines that differed from their area of specialism, their knowledge was outdated and they received little or no professional assistance. In these circumstances, it was not surprising that educators showed their willingness to get involved in further training and activities. If Romanian teachers wanted to know more about ADHD, efforts could be made to provide them with the context in which knowledge could be acquired and their expertise enhanced.

On the other hand, the results suggested that the idea of training activities was better received among the support staff. While there are very few opportunities for teachers' training in Romania, the wider body of school support staff was even more neglected. This might point to a change in the national drive for schools to conduct regular appraisals for support staff. Teacher educators could make a major contribution to children's welfare, raising standards in Romanian schools by ensuring that all support staff are receiving the training that they are asking for. A coherent coaching framework for joint teacher and

support staff training and development could be implemented, taking account of local needs and priorities.

However, the above training efforts are substantial and ambitious undertakings, which could take several years to be fully implemented. Training could prove to be expensive to design, organise and run and there may be limits in the extent to which such training can produce the desirable shifts in the culture of practice. Furthermore, training may be counter-productive as a result of positioning teachers as being in deficit. In this context, alternatives with immediate effects could be more beneficial in the short term. For instance, teachers with a high degree of interest in ADHD could be encouraged to volunteer and participate in mentoring programmes with their fellow colleagues. Collaborative activities could be designed by teachers for teachers, taking into consideration the training needs identified within a specific school. If the initiative proved to be effective, the activities could be extended to a larger number of teachers from different educational establishments. The major assumption this recommendation stems from is that involvement in volunteering develops skills and attitudes that are transferable to the political participation sphere and exposes the teaching community to experiences and mobilisation networks which enhance the opportunity for them to become active participants in their students' lives.

8.2.3. Implications for parents of children diagnosed with ADHD

8.2.3.1. Support systems for parents of children diagnosed with ADHD

In investigating parents' knowledge and attitudes, this study explored themes related to the types of services used by parents of children diagnosed with ADHD residing in Scotland and Romania and their effectiveness for reducing the parents' stress levels as well as increasing their coping skills. However, this research was not only intended to gather data, collect information about personal experiences and analyse them accordingly, but to also suggest practical ideas for providing specific support services which would ultimately meet the unique needs of parents. Despite the continuing importance of family support systems, economic, political and historical changes created new constraints on families in caring for their children. The issues that participants emphasised suggested topics that could be addressed when assessing the adequacy of support offered.

Parents' experiences of getting involved in different training activities revealed surprisingly similar responses in both cultural settings. Scottish and Romanian parents showed no interest in further developing their skills when dealing with their children diagnosed with ADHD. However, it should not be assumed that lack of involvement translates into non-caring (Finders & Lewis, 2002). This study considered that rather than parents being hard to reach, it was frequently schools, medical systems and support services themselves that inhibited accessibility for certain families.

Firstly, the effectiveness of the school systems in actually involving Scottish and Romanian parents was, in most cases, questionable. According to Crozier and Davies

(2007), instead of questioning what constrains parents from engaging with the school, we could start by asking why schools are so hard to reach. In most cases, the school policies describe the role of parents within a narrow prescribed framework. Expectations that parents and their involvement have to fit a particular set of criteria were often unrealistic. Support services tailored to each parents' needs were assigned less importance. Therefore, in both Scottish and Romanian educational contexts, there might be potential benefits of acknowledging the diversity of the parental body and the various types of involvement that they might wish. In this sense, parents need to be clear how and why they should be involved and opportunities for involvement in schools should be made available for everyone. Pathways of possibilities to engaging could be fully embedded and integrated in teaching and learning plans if it is to make a difference in the life of children diagnosed with ADHD. Room is needed for parents and teachers to come together for extended periods of time to work on specific case studies, share information and write joint reports about students. However, sometimes it seemed that the same parents were always appointed to these groups, so it is important that teachers seek out participants who might not be the first to volunteer and who represent the full student population.

Furthermore, there could be a rationale for organising all collaborative activities early in the school year in order to introduce families and school personnel within a positive setting, rather than waiting until problems arise. These events might give parents the opportunity to become familiar with school staff and to meet other parents in similar situations. In this way, parental involvement could be finally perceived as a priority that promotes access to parenting resources rather than a bolt-on extra that supports conformity (Gillies, 2005). Parents will not take an active role in the education system "unless they

know the difference that they could make and unless schools actively reinforce that all parents matter" (Harris & Goodall, 2008, p. 287).

Secondly, despite recent efforts to improve the quality of health care services, this study showed that family members developed ineffective partnerships with medical practitioners. They found it difficult to work together, could not attend to one another's concerns and did not appreciate different points of view. What was learned from these compelling stories could be taught to other practitioners, inform policy or be incorporated in models of family-centred care. For instance, ways in which poorly timed and incomprehensible information may make parents frightened and disempowered could be communicated. Giving families information might be the first step in gaining their acceptance and support, alleviating their anxieties, fulfilling their needs and opening lines of communication. The unfamiliarity of medical vocabulary and differences in understandings of models of disability could be effectively addressed by professional advice that is clear and easy to understand. These results called for health care providers to develop an effective system for information exchange that would not overwhelm parents but that would keep them informed. As a practical recommendation, medical practitioners could use photographic and video recordings of patients in similar situations or information leaflets that explains the different approaches and conceptualisations of ADHD that exist in this field today.

As well as being valued by schools, there might be both theoretical and empirical reasons to believe that parents need to feel empowered within the medical system. This aspect presumes that professionals would assist parents to find good sources of information, help them discern what is reliable, and support them in making decisions that are right for

them. Efforts could be made to develop local infrastructures to support families and to avoid further alienation and exacerbation of already existing conflicts. Taking account of parents' feelings of oppression, uncertainty and frustration, this study clearly underlines the importance of training for parents to support them in a partnership role. There might be a need for specific training which explains and clarifies the roles of various professionals and how these roles interlink.

Thirdly, Scottish and Romanian parents were not keen to belong to any form of parental support groups. Participants complained that support groups were sensationalising ADHD, offering negative and deceiving information. Before putting together a support group, the organisers could firstly ask what kind of help parents need in order to function as partners and become empowered. In this sense, I argue that support groups need to be run by parents for parents and with parents. By listening and identifying specific parents' needs, support groups could tailor services that fit within the context of the family and their cultural background. For instance, economic and social adversities contributed greatly to a general state of frustration and lack of hope about the future among Romanian families. More opportunities for parental support could decrease Romanian parents' difficulties in coping with these stressful situations. Given the financial and time constraints that they face, it might be difficult for a single parent who cannot share parenting responsibilities with a spouse to participate in activities that take them out of the home. In this context, it seems equally important to offer child care to single mothers so it would be easier for them to connect more with these support networks. Another suggestion worthy of consideration is recommending that the government identify community partners and funding sources that could provide grants to help keep parents connected. In addition, other ways to bring

parents together such as newsletters, buddy systems, social networks, workshops, and conferences might be less time-consuming and cost efficient.

Moreover, results revealed that Romanian parents had limited knowledge about ADHD and its treatment. To increase enrolment, support groups might want to focus on providing information regarding ADHD treatment, helping parents to critically understand the diversity of options that currently exists. Improved provision of education and information could help them address the debates surrounding stimulant medication and allow full participation in the treatment process. Parents' involvment might seek to highlight, and enact the complexity of ADHD treatment and open themselves up to multiple bodies of expertise.

In Scotland, inclusion was among the most controversial topics for parents. Even when parents were accepting of inclusion, they felt that additional resources were needed. Parents were constantly questioning the meaning of inclusion, and wrestling with their private understanding of their children' needs. This aspect was often presented as a question of rights but, as Lindsay (1997) argued, that was insufficient. Too often the social, economic and cultural experiences of parents were represented as serious problems rather than valued knowledge. Both the surmounting of barriers and the efficacy of the education provided must thus be considered. Indeed, in this study, parents' uncertainties were accentuated by various education policies that often reflected a discourse focused on the technical requirements needed to accommodate the difference (Allan, 2008; Slee, 2006). Parents described the awfulness of ADHD which derived from the lack of appropriate support and resources. Accordingly, efforts to support parents must go beyond their positive or negative attitudes and consider how families understand the discourse of

inclusion and its rationale. In this context, there might be a strong argument to recommend the development of more support groups where the idea that disability is not inability might be promoted and internalised among its members. The educational and social benefits of inclusion could be highlighted within traditional support groups or more complex online communities facilitated and led by parents. These groups could reserve time for individual members to discuss their own challenges and interrogate the norms, beliefs and values of inclusion. Another key strategy could involve bringing in speakers periodically to provide information about the positive effects that inclusion might have on the wider achievements of all pupils. More specifically, teachers could be invited to share their experiences about effective inclusion practices and the positive outcomes that these practices might have. Answering parents' questions and providing them with information could also help to alleviate the negative attitudes and concerns identified earlier.

8.2.3.2. Support from parents of children diagnosed with ADHD

Living in a state of chaos, parents can offer support as well as being supported. Professionals could start by changing their approach from expert models to those based on partnership with recognition of the knowledge and expertise of parents as the first and primary educator of their children. This research could be used as a tool to identify needs and develop plans that address the growing emphasis placed on parental input at the local, state and national level. It is time for policy makers, schools, providers, businesses, health care practitioners and support groups to create meaningful family involvement programmes that should be as diverse as the stories told by the Scottish and Romanian families.

At the government and local policy level, there is a need for stakeholders to understand the importance of parental involvement, how families could help, and types of approaches to take in practising effective communication with parents. Theory and current research in the field suggested that it might be beneficial to engage parents, teachers and support staff in more thorough approaches to working with each other during training, specific parent-teacher conferences, and when implementing general strategies that include all participants as stakeholders. An education programme could be developed to integrate parent education in teacher education curricula. The concept of family as co-instructors was used in the "Family as Faculty" project designed by the University of South Florida in the United States. The same project could be replicated in Scotland and Romania where universities would have the opportunity of recruiting family members as guest lecturers in education classes with the goal of training future teachers to engage with families from a variety of walks of life and listen to their voices (Family as Faculty, 2000). As well as

providing teachers with a hands-on, real life experience at a crucial time in their education, the programme could also enhance positive outcomes for families and children through informed decision making, advocacy, education and resources. It could offer a wide range of networking opportunities for families to connect with and support each other, empowering them to make a difference in the system.

Transforming parents as active partners could be considered as a process with culturally-specific implications. For instance, for Scottish parents, children's participation within mainstream education was seen as problematic, difficult to manage, time consuming and expensive. Parents were not sure what was expected of them, did not have a clear picture of how an inclusive programme operates, and did not possess sufficient knowledge of what inclusion actually was. Their determination to continue to have their children's needs met in specialist provision could represent an important message for stakeholders interested in making parents more accepting of difference. These parental perspectives could thus provide important information to guide local strategic policy formation and implementation for the education systems. In these circumstances, there is a strong rationale to clearly explain to parents the principles of inclusion, together with practical examples about how children could be included and how their learning could further develop. In other words, transforming parents as active partners in defining the process of inclusion might represent a major goal of the Scottish government at both national and local levels. However, a major challenge is to become more sensitive to parents' identified priorities, being able to work with them to address their worries and anxieties. It could be argued that, in one sense, even if parents were not supportive of mainstream inclusion, a perceptual shift could occur when policies reflect the rights of all to a quality inclusive

education and emphasise the need to see the child diagnosed with ADHD as an individual with his or her own distinct patterns of thinking and feeling. Having available policies that promote a positive understanding towards inclusion might help reduce parents' fears and concerns. At the school level, one of the most important findings that emerged from this study was the importance of the process of joining with families. A strong home-school partnership was an essential element for both Scottish and Romanian participants. Therefore, of particular importance is providing parents with clear messages regarding their roles, clarifying their rights and responsibilities, including them in planning and decision making, respecting their knowledge as caregivers and supporting their hopes for their children. More specifically, by flexibly scheduling the classes, parents could assist with the instruction, share their experiences and facilitate home-school dialogue. Different approaches to the involvement of families in after-school activities could also prove beneficial. For instance, a collaborative team of parents and educators could form a multi-family group to engage the parents in building social networks throughout the schools. The development of a facilitation team could ensure that parents' issues and concerns are dealt with in an effective manner, involving them in the ongoing planning for the child diagnosed with ADHD. The facilitator could represent the liaison between parents and teachers, help set the agendas and keep the discussions on track. As Hoover-Dempsey cited in Mapp (2003) also ascertained, validation of any contribution made by the parents could help them to feel like important contributors to the school community, increasing their efficacy and their sense of confidence in being able to help their child.

The importance of involving parents in the care of their child was an important element of this study. There are strong reasons to suggest that both Scottish and Romanian

parents did not feel empowered in the medical system and underestimated their own expert knowledge, skills and valuable insights. Therefore, if an evidence-informed approach is adopted, parents could take a more active role in both defining the problem for which they want help and in determining appropriate treatment. Sooner or later parents would become partners in accessing health care for their children, making community services more responsive to their personal needs. In order to achieve this successful partnership, health care providers need to listen to the voice of parents, including both the dilemmas that make things difficult and the success that makes their practice worthwhile. Parents need to be taken seriously and should be considered as intelligent, capable and co-operative participants, with their own cognitive and emotional needs.

Last but not least, this study suggested that parents of children diagnosed with ADHD could also be qualified to support each other and make a difference in each others' lives. The strength of any support groups lies in its members, and their willingness to share their own experiences, challenges, and solutions in the context of the group. Encouraging interaction among parents with positive experiences could represent a great way to mobilise their resources. By sharing what they know, parents could become leaders and support systems for each others. As they became more involved, they could feel more worthy of contributing to others' learning and construct a role that reflects their desire to help parents become more aware of ways to help their children. For instance, parents who experienced positive outcomes for their children could act as family consultants and provide information and support to other families. They could teach other parents important skills in advocating for inclusive placements, and the value of connecting to other parents, community services and support agencies.

8.2.4. Reconceptualising ADHD; A culturally-relevant framework for support

In this section, I propose a framework that attempts to unite much of the results and implications reviewed above. Working within this model might help teachers and parents to enhance their knowledge and attitudes towards children diagnosed with ADHD. This model is targeted at the multitude of factors that surround ADHD, rather than at the diagnosis itself. The fundamental idea of this framework is that it moves beyond the deficit paradigm, illustrating the likelihood that such constructions of disability will only partially account for the phenomenon of ADHD. However, it must be noted that it is not my intention to dismiss the complexity of ADHD, nor simplify its controversies. I am not rejecting the diagnosis of ADHD but I am emphasising the extent to which society, media, political orientations and various technologies contribute to the development of clinical symptoms. In this context, ADHD could be seen as roulette. Depending on where the ball in the wheel stops, ADHD could have a different conceptualisation within a wider social, economical and political environment.

In the framework, any intervention or support system could start by taking account of three significant assumptions. Firstly, globalisation in the economic, political, social, cultural, environmental and technological spheres has led to rapid changes in the configuration of societies. Teachers and parents have an important role and task in this regard. They need to be aware of the impact of globalisation in the context of changing language, idioms of distress, explanatory models and help-seeking. Secondly, the current conceptualisation of ADHD could be challenged. I contend that a shift towards an understanding of ADHD from a critical perspective is needed for everyone involved in the

life of children diagnosed with ADHD. I make an extended case for the need to deconstruct the disability models related to ADHD, before initiating any framework for support and guidance. Indeed, irrespective of the type of support offered, caution needs to be exercised about taking a narrow definition of ADHD. Rather than promoting a medical or social explanation for children's behaviour, the current debates about disability need to be presented. For teachers and parents, the task is to be alert and responsive to the various conceptualisations of ADHD and to understand how these schemata have come into existence in specific periods of time. Simultaneous consideration of the models of disability might be necessary to gain a complete picture of ADHD. By exposing and critically assessing some of the key positions in the field of ADHD, this framework aims to give teachers and parents the language and arguments necessary to improve their practice. Thirdly, the lived experience and construction of ADHD cannot be divorced from the particular social, cultural and developmental context in which it is located. Understanding how various scapes differ from one country to another is critical for improving practices and developing support services. Parents, teachers and support staff could be helped to become inquirers who question how the ethnoscapes, mediascapes, technoscapes and ideoscapes are at work in their lives. They might become readers of the myriad of scapes and take into account that their knowledge and attitudes are influenced by a wide variety of factors such as economic resources, geography, support services, transportation, media, messaging, work sites, or the schools. A better evaluation of the individuals' scapes along with a critical inquiry into the rhetoric and actions surrounding ADHD could form the starting point for any effort to improve children's lives.

Therefore, based on the results obtained in both cultural settings, I propose a strategic planning process which can be implemented at different levels and with various topics of interests. Considering the move towards the globalisation of ADHD and its professional services, support systems could have the same structure in each country but the services they are providing might have a different focus specific to the cultural contexts. In this sense, the framework is individualised and flexible by acknowledging that contexts for parents' and teachers' manifestations differ across countries. Although each node in the framework is shown as connected to another, they are by no means fixed and have an interchangeable position in the middle of all the flows. They are continuously being adapted and augmented as changes take place in society, as scapes flow and as our understanding progresses.

The proposed framework is presented in Figure 14.

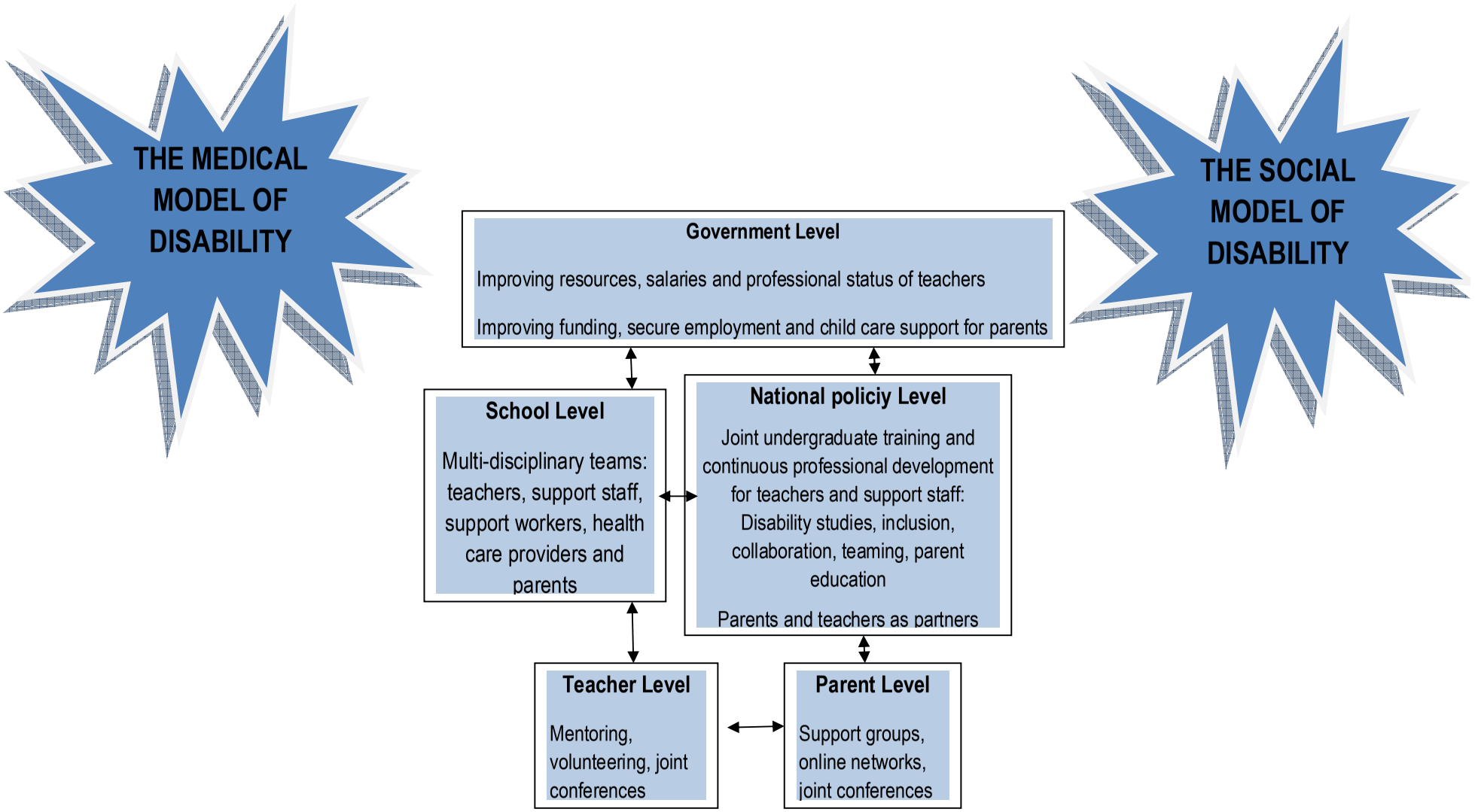

Figure 14. A culturally-relevant framework for support

8.2.5. Final thoughts

My PhD was an apprenticeship in academia, a learning journey about getting to know who I am as a researcher and what type of researcher I would like to become in the future. Coming from a Romanian educational system when you are always told what to do and you just obey, this PhD gave me the opportunity to develop intellectually, socially and emotionally. It installed a sense of critical sense, making me unwilling to accept the common standards and norms. Although my previous research projects were guided by a more positivist paradigm, I found myself naturally questioning my own assumptions about the conceptualisation of ADHD and became particularly interested in the specific factors that support and hinder parents' and teachers' knowledge and attitudes towards ADHD. Rather than only looking at various correlations and causal relationships between variables, I was also able to capture the complexities of ADHD, recognising it as spatially, socially and temporally situated a phenomenon that is culturally specific and individually experienced. During the course of my research, I became more literate about reading different scapes and gained a politicised understanding of ADHD that helped me understand what type of support is needed to develop and sustain effective practices. Nevertheless, meeting so many parents of children diagnosed with ADHD was unique and rich in both intellectual and interpersonal stimulation and reward. The experience of working in a hospital setting has been very important for me as it was a starting point for acquiring skills which are transferable into nonacademic workplaces, skills which have since grown and developed.

Doing a PhD was hard, but to quote one of my favourites lines:

> It is supposed to be hard; If it was not hard, everyone would do it; The "hard" is what makes it great. (Tom Hanks, 1992)

Indeed, my PhD was a learning process where probably mistakes were made. However, the most important aspect is to reflect on your experience and try to improve it. I can see very clearly now that my PhD is another step in what will be a career in which I will never stop learning and challenging myself.

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Appendix A: Original KADDS Items

Sciutto & Feldhamer, (2000)

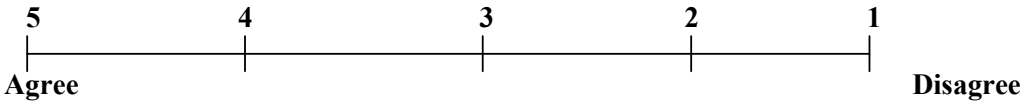
Please answer the following questions regarding Attention-Deficit/Hyperactivity Disorders (ADHD). If you are unsure of an answer, respond Don't Know (DK), DO NOT GUESS.

1. T F DK Most estimates suggest that ADHD occurs in approximately 15% of school age children.
2. T F DK Current research suggests that ADHD is largely the result of ineffective parenting skills.
3. T F DK ADHD children are frequently distracted by extraneous stimuli.
4. T F DK ADHD children are typically more compliant with their fathers than with their mothers.
5. T F DK In order to be diagnosed with ADHD, the child's symptoms must have been present before age 7.
6. T F DK ADHD is more common in the 1st degree biological relatives (i.e. mother, father) of children with ADHD than in the general population.
7. T F DK One symptom of ADHD children is that they have been physically cruel to other people.
8. T F DK Antidepressant drugs have been effective in reducing symptoms for many ADHD children.
9. T F DK ADHD children often fidget or squirm in their seats.
10. T F DK Parent and teacher training in managing an ADHD child are generally effective when combined with medication treatment.
11. T F DK It is common for ADHD children to have an inflated sense of self-esteem or grandiosity.
12. T F DK When treatment of an ADHD child is terminated, it is rare for the child's symptoms to return.
13. T F DK It is possible for an adult to be diagnosed with ADHD.
14. T F DK ADHD children often have a history of stealing or destroying other people's things.
15. T F DK Side effects of stimulant drugs used for treatment of ADHD may include mild insomnia and appetite reduction.
16. T F DK Current wisdom about ADHD suggests two clusters of symptoms: One of inattention and another consisting of hyperactivity/impulsivity.
17. T F DK Symptoms of depression are found more frequently in ADHD children than in non-ADHD children.

18. T F DK Individual psychotherapy is usually sufficient for the treatment of most ADHD children.
19. T F DK Most ADHD children "outgrow" their symptoms by the onset of puberty and subsequently function normally in adulthood.
20. T F DK In severe cases of ADHD, medication is often used before other behavior modification techniques are attempted.
21. T F DK In order to be diagnosed as ADHD, a child must exhibit relevant symptoms in two or more settings (e.g., home, school).
22. T F DK If an ADHD child is able to demonstrate sustained attention to video games or TV for over an hour, that child is also able to sustain attention for at least an hour of class or homework.
23. T F DK Reducing dietary intake of sugar or food additives is generally effective in reducing the symptoms of ADHD.
24. T F DK A diagnosis of ADHD by itself makes a child eligible for placement in special education.
25. T F DK Stimulant drugs are the most common type of drug used to treat children with ADHD.
26. T F DK ADHD children often have difficulties organizing tasks and activities.
27. T F DK ADHD children generally experience more problems in novel situations than in familiar situations.
28. T F DK There are specific physical features which can be identified by medical doctors (e.g. pediatrician) in making a definitive diagnosis of ADHD.
29. T F DK In school age children, the prevalence of ADHD in males and females is equivalent.
30. T F DK In very young children (less than 4 years old), the problem behaviors of ADHD children (e.g. hyperactivity, inattention) are distinctly different from age-appropriate behaviors of non-ADHD children.
31. T F DK Children with ADHD are more distinguishable from normal children in a classroom setting than in a free play situation.
32. T F DK The majority of ADHD children evidence some degree of poor school performance in the elementary school years.
33. T F DK Symptoms of ADHD are often seen in non-ADHD children who come from inadequate and chaotic home environments.
34. T F DK Behavioral/Psychological interventions for children with ADHD focus primarily on the child's problems with inattention.
35. T F DK Electroconvulsive Therapy (i.e. shock treatment) has been found to be an effective treatment for severe cases of ADHD.
36. T F DK Treatments for ADHD which focus primarily on punishment have been found to be the most effective in reducing the symptoms of ADHD.

Appendix B-The first version of the self-rated attitude questionnaire

Please read the items listed below very carefully. Think about the students with ADHD you have taught in the past, try to be as honest and circle the number that represents you in the best way possible.



1. I'm always trying to convince students with ADHD to believe they can do well in school work; A(+)
2. Inclusion offers mixed group interaction which will foster understanding and acceptance of differences between pupils; C(+)
3. I see the need to implement changes in the classroom management to accommodate the needs of students with ADHD; B(+)
4. I use the same disciplinary rules for all the children in my class; B (-)
5. I believe that I would be more successful teaching children with ADHD if I will receive more specialized support; A (+)
6. The responsibility for educating children with ADHD rests with the medical community; B(-)
7. I believe that children with ADHD are just lazy; C(-)
8. The challenge of being in an ordinary classroom will lead to academic underachievement for children with ADHD; C(-)
9. Students diagnosed with ADHD can learn successfully in the mainstream classrooms; C(+)
10. ADHD children misbehave because they are naughty; C(-)
11. Teachers have the responsibility to believe in students, to assess and direct students' educational needs regardless of their abilities; A(+)
12. I would prefer not to teach in a school with so many children diagnosed with ADHD;A(-)
13. I am willing to change my teaching strategies to accommodate children with ADHD; B(+)
14. I think the present curriculum is adequate for serving the needs of students with ADHD; C (-)
15. I am keen to engage in developing skills for managing the behavior of children with ADHD; B(+)
16. The education system should be more lenient towards ADHD students; B(+)
17. I often work under a lot of pressure as usually teachers are expected to be experts on managing disruptive behaviors; A(-)
18. I would like to engage in more trainings on how to deal with children with ADHD; B(+)
19. Children with ADHD have the same rights as all other children; C(+)
20. ADHD is a legitimate educational problem and more attention needs to be given to it by teachers; A(+)
21. I usually vary the instructional level for different-ability students in my classroom; B (+)

22. Teachers should allow the presence of parents in class for children with ADHD; C(-)
23. All schools should have special education teachers and therapists to provide services for ADHD children who are currently in the school; C(+)
24. I feel I cannot make any differences in the education of children with ADHD; A(-)
25. Curricula and textbooks generally ignore the education of persons with special needs; C(+)
26. Behavior of children with ADHD will set an undesirable example the other classmates; C(-)
27. I don't believe that teachers have the time and resources to implement adequate intervention for children with ADHD; B(-)
28. Most kids whose parents think they have ADHD are just normal kids with situational or parenting problems; C(+)
29. I feel overwhelmed by having to teach so many children with ADHD in the same class; A(-)
30. Inclusion of children with ADHD will not be beneficial for the other regular class children; C(-)
31. I think teachers should try classroom interventions to improve children's academic achievement before referring them for a special education evaluation; B(+)
32. Patients can be stigmatized and disadvantaged by the diagnosis of ADHD; C(+)
33. I am proud of my ADHD students accomplishments; A(+)
34. Children need to be protected from classmates who have ADHD; C(-)

Legend:

A= The affective component of attitude;

B= The behavioral component of attitude;

C= The cognitive component of attitude;

''+''=Positive Item;

''--''= Negative Item;

UNIVERSITY OF STIRLING

Project title: *Knowledge and attitudes towards Attention Deficit Hyperactivity Disorder (ADHD;*

Principal Investigator: *Madalina Toma, Research Student, School of Education, University of Stirling ;*

Supervisor: *Prof. Julie Allan, Deputy Head of School, School of Education, University of Stirling*

APPENDIX C:

SELF-REPORT QUESTIONNAIRE FOR TEACHERS AND SUPPORT STAFF

- This questionnaire is for all teachers and support staff members in the school;
- We are interested in learning more about teachers' experiences, challenges and achievements in relation to Attention Deficit Hyperactivity Disorder (ADHD);
- If there is a question you do not wish to answer, simply skip it;
- We hope you will answer as many questions as possible;
- Your responses are voluntary and confidential;
- No individual teachers or their schools will be identified in any reports;

Part 1:

Please answer the following questions regarding Attention Deficit/Hyperactivity Disorder (ADHD). If you are unsure of an answer, respond Don't Know (DK), DO NOT GUESS

True (T), False (F), or Don't Know (DK) (circle one):

1. **T F DK** Symptoms of depression are found more frequently in children diagnosed with ADHD children than in other children.

2. **T F DK** A diagnosis of ADHD makes a child eligible for placement in special education.

3. **T F DK** Individual psychotherapy is usually sufficient for the treatment of most children diagnosed with ADHD.

4. **T F DK** In school age children, the prevalence of ADHD diagnosis is equivalent in males and females.

5. **T F DK** Cognitive behavioural therapy for children diagnosed with ADHD focuses primarily on the child's problems with inattention.

6. **T F DK** Children with ADHD are more distinguishable from children non-diagnosed with ADHD when they are involved in a structured activity rather than in a free play situation.

7. **T F DK** Reducing dietary intake of food additives is generally sufficient in reducing the symptoms of ADHD.

8. **T F DK** In primary school the majority of children diagnosed with ADHD exhibit some degree of poor school performance.

9. **T F DK** Stimulant medication is the most common type of medication used to treat children diagnosed with ADHD.

10. **T F DK** Punishment has been found to be sufficient in reducing the symptoms of ADHD.

11. **T F DK** Children diagnosed with ADHD are frequently distracted by background noises that are unrelated to the focus task.

12. **T F DK** In order to receive a clinical diagnosis of ADHD, the child's symptoms must have been present before age 7.

13. **T F DK** Children diagnosed with ADHD often fidget in their seats.

14. **T F DK** Current knowledge about ADHD suggests two clusters of symptoms: One of poor concentration and another consisting of hyperactivity/impulsivity.

15. **T F DK** In order to be clinically diagnosed as having ADHD, a child must show symptoms across two contexts such as home and school.

16. **T F DK** Children diagnosed with ADHD often have difficulties organizing tasks and activities.

Part 2:

Please read the items listed below very carefully. Think about the students with ADHD you have taught in the past, try to be as honest and circle the number that represents you in the best way possible

17. I try to convince students diagnosed with ADHD that they can do well in school.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

18.I feel overwhelmed by the responsibility of managing the behaviour of students diagnosed with ADHD.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

19.I believe that I would be more successful in teaching children diagnosed with ADHD if I receive more specialized support from:

a) Psychologist

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

b) General medical practitioner

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

c) Child and Adolescent Psychiatrist/ Pediatrician

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

d) University/academics

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

e) Other (please state).....

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

20.I am proud of what my students diagnosed with ADHD have achieved so far.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

21.I believe that students diagnosed with ADHD are using the diagnosis as an excuse for being lazy.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

22.Students diagnosed with ADHD can learn successfully in the mainstream classrooms.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

23.Although students may be diagnosed with ADHD, these students have the same rights as all other children.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

24.The behaviour of students diagnosed with ADHD will set an undesirable example for their classmates.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

25.Children need to be protected from students who are diagnosed with ADHD;

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

26.I am keen to engage in developing skills for managing the behaviour of students diagnosed with ADHD.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

27.Teachers should not be so strict in implementing disciplinary policies when it comes to students diagnosed with ADHD.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

28.The provisions for children diagnosed with ADHD should be provided only by the medical community.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

29.I think parents should try helping their child with ADHD before referring them for referring him/her for diagnostic assessment.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

30.I do not believe that teachers have the time to implement adequate intervention for students diagnosed with ADHD

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

31.Parents have to treat their children equally, regardless of whether they are diagnosed with ADHD or not.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

PART 3: DEMOGRAPHIC FORM

1. What group age are you in:

☐ Under 25 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ 45-49 ☐ 50-54

☐ 55-59 ☐ 60 or over

2. Please indicate what is the highest degree you have achieved until now:

☐ Baccalaureate Diploma/Scottish Standard Grades ☐ Undergraduate University Degree

☐ Professional degree ☐ Master degree ☐ PhD-EdD ☐ Other (please indicate)

3. Please tell us how long (approximately) you have been ....(please write the number of years for each and include past years as decimals e.g. half a year is 0.5)

...in teaching (working) in a mainstream school ☐

...in teaching (working) in a special school ☐

...other (please state) ☐

4. Have you taught (work with) one or more children diagnosed with ADHD in mainstream classes?

☐ No ☐ Yes

If yes how many years experience of teaching (working with) children with ADHD have you had?

.....

Please comment on this experience.....

5. Have you taught (worked with) children with ADHD in a special class?

☐ No ☐ Yes

If yes how many years experience of teaching (working with) children with ADHD have you had?

.....

Please comment on this experience.....

6. Have you ever:

a) Taken university classes which have provided you with any information concerning ADHD?

☐ YES ☐ NO

If yes, please comment on this experience.....

b) Attended an in-service presentation on ADHD?

☐ YES ☐ NO

If yes, please comment on this experience.....

c) Attended any conference which has provided you with any information about ADHD?

☐ YES ☐ NO

If yes, please comment on this experience.....

d) Participated in any workshop on ADHD?

☐ YES ☐ NO

If yes, please comment on this experience.....

Are there any other sources of information about your experiences with ADHD that have informed your knowledge and pedagogy?

.....

.....

.....

If you are interested in taking part in a follow up interview about this research, please could you provide your contact details below:

Your Name:
Name of the school:
Class you are currently teaching (working):
Telephone number:
Email address:
Most suitable time for contact:

Thank you for taking the time to complete this questionnaire.
We greatly appreciate your contribution to the study!

***Project title**: Knowledge and attitudes towards Attention Deficit Hyperactivity Disorder (ADHD;*

***Principal Investigator**: Madalina Toma, Research Student, School of Education, University of Stirling*
;
***Supervisor**: Prof. Julie Allan, Deputy Head of School, School of Education, University of Stirling*

APPENDIX D:

SELF-REPORT QUESTIONNAIRE FOR PARENTS

Demographic information

What group age are you in:

☐ Under 25 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60 or over

Please indicate what is the highest degree you have achieved until now:

☐ No formal qualifications ☐ Baccalaureate/ Scottish Standard Grades

☐ Undergraduate University Degree ☐ Professional Degree ☐ Master Degree

☐ PhD-EdD ☐ Other (please indicate)

Part 1: *Please answer the following questions regarding Attention Deficit/Hyperactivity Disorder (ADHD). If you are unsure of an answer, respond Don't Know (DK), DO NOT GUESS*

True (T), False (F), or Don't Know (DK) (circle one):

1. **T F DK** Symptoms of depression are found more frequently in children diagnosed with ADHD children than in other children.

2. **T F DK** A diagnosis of ADHD makes a child eligible for placement in special education.

3. **T F DK** Individual psychotherapy is usually sufficient for the treatment of most children diagnosed with ADHD.

4. **T F DK** In school age children, the prevalence of ADHD diagnosis is equivalent in males and females.

5. **T F DK** Cognitive behavioural therapy for children diagnosed with ADHD focuses primarily on the child's problems with inattention.

6. **T F DK** Children with ADHD are more distinguishable from children non-diagnosed with ADHD when they are involved in a structured activity rather than in a free play situation.

7. **T F DK** Reducing dietary intake of food additives is generally sufficient in reducing the symptoms of ADHD.

8. **T F DK** In primary school the majority of children diagnosed with ADHD exhibit some degree of poor school performance.

9. **T F DK** Stimulant medication is the most common type of medication used to treat children diagnosed with ADHD.

10. **T F DK** Punishment has been found to be sufficient in reducing the symptoms of ADHD.

11. **T F DK** Children diagnosed with ADHD are frequently distracted by background noises that are unrelated to the focus task.

12. **T F DK** In order to receive a clinical diagnosis of ADHD, the child's symptoms must have been present before age 7.

13. **T F DK** Children diagnosed with ADHD often fidget in their seats.

14. **T F DK** Current knowledge about ADHD suggests two clusters of symptoms: One of poor concentration and another consisting of hyperactivity/impulsivity.

15. **T F DK** In order to be clinically diagnosed as having ADHD, a child must show symptoms across two contexts such as home and school.

16. **T F DK** Children diagnosed with ADHD often have difficulties organizing tasks and activities.

Part 2: *Please read the items listed below very carefully. Think about your own child diagnosed with ADHD, try to be as honest and circle the number that represents you in the best way possible:*

17. I try to convince my child that he/she can do well in life.
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

18. I feel overwhelmed by the responsibility of managing the behaviour of my child;
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

19. I believe that the relationship with my child will improve if I receive more specialized support from:

a) School counsellor
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

b) Psychologist
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

c) Doctor/psychiatrist
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

d) University/academics
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

e) Other (please state).....
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

20. I am proud of what my child has achieved so far.
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

21. I believe that my child is using the diagnosis of ADHD as an excuse for being lazy;
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

22. My child can learn successfully in the mainstream classrooms.
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

23. Although my child was diagnosed with ADHD, he/she has the same rights as all the other children;
Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

24. Sometimes my child behaviour can set an undesirable example for his friends and colleagues.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

25. Children need to be protected from anyone who is diagnosed ADHD;

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

26. I am keen to engage in developing skills for managing the behaviour of my child diagnosed ADHD.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

27. Teachers should not be so strict in implementing disciplinary policies when it comes to students diagnosed with ADHD.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

28. The provisions for children diagnosed with ADHD should be provided only by the medical community.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

29. I think teachers should try classroom interventions, before referring a student for diagnostic assessment;

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

30. I don't believe that I have the time to implement adequate intervention for my child with ADHD

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

31. Teachers have to treat their children equally, regardless of whether they are diagnosed with ADHD or not.

Strongly Disagree.....1.....2.....3.....4.....5.....Strongly Agree

If you are interested in taking part in a follow up interview about this research, please could you provide your contact details below:

Your Name:
Your child's name:
Address:
Telephone number:
Email address:
Most suitable time for contact:

Thank you for taking the time to complete this questionnaire.
We greatly appreciate your contribution to the study!

APPENDIX E

INTERVIEW SCHEDULE FOR TEACHERS

KNOWLEDGE ABOUT ADHD

Diagnosis process

- When did you first learn about ADHD?
- How much did you know about ADHD before you encountered the first student with this diagnosis?
- Where do you get most of your information about ADHD?
- Were you ever sceptical about it, and if so, when did you change your mind?
- Do you have any information about how children are diagnosed as having ADHD?
- What is the diagnosis pathway?
- Have you ever referred children for an ADHD evaluation? If yes, what were the main reasons for doing so?
- In your opinion, what do you think are the effects of the reference to children as having ADHD?

Associated features

- If you were to describe ADHD to a new student teacher who is unfamiliar with the disorder, how would you describe it?
- In your own words tell me what ADHD means to you?
- What do you think are the main reasons for ADHD?
- What do you call the students' difficulties?
- Why do you think it started when it did?
- What do you believe causes ADHD?

Symptoms of ADHD

- How do you describe the behaviour of students diagnosed with ADHD?
- Could you compare and contrast the behaviour of a student diagnosed with ADHD with that of peers?

Treatment of ADHD

- In your opinion, what do you think is the best treatment for ADHD?
- How do you think and feel about methylphenidate (or other psychostimulant) treatment?
- Do you think psychostimulant treatment is helping children to achieve better outcomes in the classroom? Why, why not and in what way?

ATTITUDES TOWARDS ADHD

Cognitive attitudes

Stereotypes and labeling

- What were your experiences related to teaching a student diagnosed with ADHD?
- Can you tell me how a diagnosis of ADHD could impact on the students' educational experience and their social life?
- How do you think other people understand ADHD? (parents, medical practitioners, community, etc)
- In what ways other professionals respond to ADHD?

Educational placement and inclusion

- How would you define the word diversity?
- Do you think that students diagnosed with ADHD should be enrolled in mainstream or special schools? Please motivate your choice.
- How well do you think children diagnosed with ADHD fit into the mainstream school environment?
- What benefits do you perceive for yourself and your students when teaching in a classroom with learners having diverse backgrounds and needs?
- What concerns do you have for yourself and your students when teaching in a classroom with learners having diverse backgrounds and needs?
- What questions do you have regarding addressing the needs of learners with diverse needs?

Affective attitudes

- How do you feel about working with children diagnosed with ADHD?
- At the beginning of the year how did you feel when you found out that a student diagnosed with ADHD would be in your classroom?
- How easy or difficult is it for you to teach students diagnosed with ADHD?
- What concerns do you have in teaching students diagnosed with ADHD? What implication does ADHD have for your daily practice?
- What is most meaningful about your experiences of teaching students diagnosed with ADHD?
- What is most challenging about your experiences of teaching students diagnosed with ADHD?

Behavioural attitudes

Strategies and interventions

- If you could create the ideal classroom for a student diagnosed with ADHD, what it would look like and why?
- Describe any strategies you used to overcome the challenges related to ADHD (e.g. support services/programs/interventions/accommodations)
- How has teaching students diagnosed with ADHD changed your lesson planning, teaching, or effectiveness? Is this easier or more difficult for you?
- How has teaching students diagnosed with ADHD changed the learning environment? Is this easier or more difficult for you?
- How confident are you in your abilities and competencies at teaching students diagnosed with ADHD?
- What do you need to learn more about to more effectively teach students diagnosed with ADHD? Did you tried to find out more about ADHD? If so, where did you look for information?
- Who has had the most influence on your experiences teaching students diagnosed with ADHD? What has been their influence? How have they made teaching students diagnosed with ADHD easier or more difficult for you?
- In what sort of training activities would you like to get involved in the future?

Co-operation and collaboration

- Talk to me about the level of support you feel you receive related to the ADHD diagnosis. (e.g. parents, medical practitioners, community, others)
- What in your opinion would have been helpful at the outset to assist you in becoming more effective in handling the special needs of these children in your classroom? Please provide us with suggestions on how we can assist classroom teachers to become more prepared.
- What is your relationship with the family of the students diagnosed with ADHD? Has the family helped? In what ways?
- What strategies would best enhance the collaboration of parents and teachers when working with children diagnosed with ADHD?

APPENDIX F

INTERVIEW SCHEDULE FOR PARENTS

KNOWLEDGE ABOUT ADHD

Diagnosis process

- When did you discover your child had ADHD? (When did you first learn about ADHD?)
- What issues prompted you to seek a diagnosis?
- What did you think about the diagnosis process?
- Were you ever skeptical about it, and if so, when did you change your mind?
- How much did you know about ADHD before your child was diagnosed?
- Where do you get most of your information about ADHD?

Associated features

- If you were to describe ADHD to someone who is unfamiliar with the disorder, how would you describe it?
- In your own words tell me what ADHD means to you?
- What do you think are the main reasons for ADHD?
- What do you or your family call your child's difficulties?
- Why do you think it started when it did?
- What do you believe causes ADHD?

Symptoms of ADHD

- How would you describe your child's behavior?
- Could you compare and contrast your child's behavior with that of siblings or peers?

Treatment of ADHD

- What is the current treatment plan for your child and how was it decided?
- In your opinion, what do you think is the best treatment for ADHD?
- How do you think and feel about methylphenidate (or other psychostimulant) treatment?
- Do you think that psychostimulant treatment is helping your child? Why, why not and in what ways?

ATTITUDES TOWARDS ADHD

Cognitive attitudes

Stereotypes and labeling

- Can you tell me how ADHD has impacted your child's educational experience and his social life?
- How do you think other people understand ADHD? (teachers, other professionals, etc)
- In what ways other professionals respond to ADHD?

Educational placement and inclusion

- How well does your child fit into the present school environment?
- Do you think that your child should be enrolled in a mainstream or special school? Please motivate your choice.
- What benefits do you perceive for your child when learning in a classroom with students having diverse backgrounds and needs?
- What concerns do you have for your child when learning in a classroom with students having diverse backgrounds and needs?

Affective attitudes

- At the time of your child's diagnosis, what thoughts were going through your mind and how did you feel?
- How easy or difficult is to be a parent of a child diagnosed with ADHD?
- How has the diagnosis changed you and your family life?
- What is most meaningful about your experiences of being a parent of a child with a diagnosis of ADHD?
- What is most challenging about your experiences of being a parent of a child with a diagnosis of ADHD?

Behavioral attitudes

Strategies and interventions

- If you could create the ideal home environment for a child diagnosed with ADHD, what it would look like and why?
- Describe any strategies you used to overcome the challenges related to ADHD (e.g. use of ADHD medication, support services/programs/interventions/accommodations)
- How confident are you in your abilities and competencies as a parent?
- Did you feel like you had to make some changes in your parental style in response to the ADHD symptoms?
- How did you learn to manage ADHD?
- What do you need to learn more about to more effectively meet the needs of your child?
- In what type of activities would you like to get involved in the future?

Co-operation and collaboration

- Can you tell me what support you have received in relation to your child's diagnosis. (e.g. teachers, medical practitioners, community, family, others)
- Do you have any suggestions that you feel could be offered as possible ways of enhancing and improving a situation such as your own? Please provide us with suggestions on how we can assist parents to become more prepared.
- What do you make of the Scottish/ Romanian school system overall? (Open classes, notions of equality among students/not streamed, teaching standards, resources, length of schooling, etc)
- What is your relationship with the school? Has the school helped? In what ways (e.g. accepting the diagnosis, getting support, making you feel different about the child's school performance, etc)?
- What strategies would best enhance the collaboration of parents and teachers when working with children diagnosed with ADHD?

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

UNIVERSITY OF STIRLING

Madalina Toma (BA/MA/MRes)
PhD Research Student
The Stirling School of Education
m.t.toma@stir.ac.uk

Working together for children with ADHD

ATTENTION DEFICIT HYPER ACTIVITY DISORDER

What is the research about?

The aim of this study is to understand how teachers feel, think and act in relation to ADHD;

Why is the research being done?

The importance of teachers' role is often overlooked in research and therefore this project will represent a key opportunity to learn more about what you know about ADHD and to understand your everyday experiences, challenges and achievements;

What will I be asked to do?

✓Complete a self-report questionnaire- 15 minutes;

✓Take part in an one hour interview-(only if selected);

Are there any possible benefits of taking part in the study?

✓Your involvement in the study may give you satisfaction that you have contributed to important research, which may affect the future care offered to children/students diagnosed with ADHD;

✓Being part of this project will give you the opportunity to express your voice and help other teachers to learn from your personal experience;

APPENDIX H:
COUNCIL APPROVAL LETTER

Education

Madalina Teodora Toma

Tel:
Fax:

Date: 6 April 2011

Dear Madalina

Request for Research

Thank you for completing the pro-forma regarding research which you intend to carry out within It is important that you identify the five schools you intend to approach initially in order that a copy of this letter can be forwarded to the headteachers.

I have signed the pro-forma which is attached.

Final approval should be sought from the headteacher of each school. I note your Disclosure Scotland certificate details you have provided which is required when working with children and young people.

Yours sincerely

pp Joanne Scott

Head of Education

AB

X

REQUEST FOR ACCESS TO SCHOOLS FOR THE PURPOSE OF EDUCATIONAL RESEARCH

Your Name:	**MADALINA TEODORA TOMA**
Your Address:	
Your Post:	**POSTGRADUATE RESEARCH STUDENT**
Your Employer:	**UNIVERSITY OF STIRLING** **SCHOOL OF EDUCATION** **STIRLING , FK9 4LA, SCOTLAND, UK**
Title of your Project:	**Primary School Teachers' Knowledge and Attitudes towards Attention Deficit Hyperactivity Disorder (ADHD)**

Context and purpose of the research (e.g. M.Ed dissertation, personal study, project funded by Scottish Government)

Programme of Study: Doctor of Philosophy Education
Programme Start Date: 01/Oct/2009
Expected End Date: 30/Sep/2012
Mode of Attendance: Full time

This PhD research is funded by the Stirling School of Education, University of Stirling and the Economic and Social Research Council (ESRC).

[redacted]

When do you intend to begin your work with schools/teachers?

- Subject to [redacted] the selected primary schools will be contacted. Appointments will be arranged with the headteachers and the Head of Establishment for SEBN Support Service (Primary), explaining the motivation for and the importance of the study.
- The average starting date for the fieldwork is expected to be early May 2011.

When do you expect to complete your work with schools/teachers?

The proposed fieldwork is expected to be completed by the end of December 2011.

When will the research as a whole be completed?

The research project will be completed and the final thesis submitted before 30th September 2012.

What would you be asking schools or teachers to do? (e.g. fill in 6 page questionnaire, 40 minute interview, allow observation of six lessons)

BRIEF OVERVIEW OF THE RESEARCH METHODOLOGY

The research methodology will involve a survey and interviews with teachers and support staff.

Phase 1 (May 2011-July 2011)- ''Identifying patterns''

The first step will involve a survey of teachers. Mainstream primary school teachers (P3-P7) and support staff will be asked to complete a short self-report questionnaire about their knowledge and attitudes towards ADHD. Participants will be personally contacted and questionnaires will be given for completion at school at an agreed time.

The survey instrument was developed by using some existing scales (E.g. Knowledge of Attention Deficit Disorder Scale-KADDS) from prior instruments and by creating additional items which fit the construct definitions and the culturally linked factors. KADDS was obtained directly from Prof. Mark Sciutto (Muhlenberg College, U.S.A) who designed the instrument and granted permission for its utilization in this particular study. The instrument was piloted and all the psychometric properties were carefully tested prior to administration. The self-report questionnaire includes 31 items (16 items-knowledge about ADHD and 15 items-attitudes towards ADHD) and a brief demographic inventory.

Phase 2 (August 2011-December 2011) "Gaining insight and understanding meanings"

After the questionnaires have been completed, a selected number of 5 teachers and 5 support staff members will be invited to take part in a 60 minutes audio-recorded interview. If selected, during the interview, the questionnaire items will be further discussed, in order to uncover and understand teachers' everyday experiences, challenges or achievements. Interviews will be carried out within the school environment at a mutually agreed time. However, if necessary, other meeting places most convenient to participants can be arranged.

- The validated self-report questionnaire will be attached to this form;

How many schools and teachers would be involved?

THE RESEARCH SAMPLE

- **Mainstream primary school teachers and Support Staff members from the following grades:**

Primary 3 (aged 6–7)
Primary 4 (aged 7–8)
Primary 5 (aged 8–9)
Primary 6 (aged 9–10)
Primary 7 (aged 10–11)

There are 41 primary schools in the (1 with Gaelic medium provision). A purposive sample of 5 primary schools will be initially selected. Eligibility criteria included accessibility, safety, mixed gender schools, the presence of support staff and Headteacher/School Board consent.

Approximately 70 teachers and 36 support staff (principal teachers, team leader of inclusion, support teaching staff, inclusion support workers and support for learning assistants) will be invited to take part in the initial survey. In the second part of the study, only 5 teachers and 5 support staff members will be recruited to participate in an electronically recorded interview.

How much time would be involved for each individual during working hours?

The participants will meet with the researcher on one or maximum two occasions:

-**First meeting**: approximately 70 teachers and 36 support staff members will complete a self-report questionnaire-approximately 15 minutes;

-**Second meeting** (only if selected): 5 teachers and 5 support staff members will take part in a face to face interview- approximately one hour;

- The detailed research protocol will be attached to this form;

How much time would be involved for each individual outside working hours?

No time will be involved.

Please state any way in which the research would involve pupils:

No children enrolled in will be taking part in this research.

Is any organisation involved in any way?

No other organisation is involved in this research.

To whom will you be reporting your research, and in what form?

- The final, corrected version of the thesis produced as a requirement for obtained the degree of Doctor of Philosophy in Education will be electronically submitted to the University of Stirling via STORRE: Stirling Online Research Repository. Once the electronic copy is deposited, paper copies (hardbound and softbound) will be also submitted to the University of Stirling Student Matriculation and Records Office. Theses in the University Repository are made publicly available on the Web (storage on a reliable, academic website, Google & other search services).
- The purposed project is also funded by the Economic and Social Research Council (ESRC) who operates a mandatory Datasets Policy whereby it is expected the data emerging from this research to be offered to the UK Data Archive for archiving.
- Strict confidentiality and anonymity will be observed and no individual or organisation involved in this project will be named in any report or publication.

Are you willing to provide Council Education with a summary of your findings:

- All participants will be informed about the results and what outcomes are being achieved during the whole research process. Telephone and email contacts of the researcher will be made available to teachers and support staff so that they can seek information at any time. If requested, participants can get involved in any phase of the research, explaining their questionnaire answers or editing their interview transcriptions.

- Education Service will receive a short report summarising the findings as soon as the study is completed. If requested, a draft copy of the proposed publication can be provided. Any scientific publications and educational materials resulted from the research will be shared with the aim of providing significant resources for education and training.

Please list any specific schools you plan to involve:

Any other information you wish to add:

The study was approved and ethical clearance was obtained from both University of Stirling and The Economic and Social Research Council Research Ethics Committees.

It is a requirement that you are in possession of a current Disclosure Scotland certificate.

Date of Disclosure: **03/02/2011**

Disclosure Number: **120100096226784**

Please confirm above with your signature and date

Signature: Madalina Teodora Toma Madalina Teodora Toma Date 5th of April, 2011

FOR AUTHORITY USE ONLY

This request for research access has the support of Council Education

Signed: Joanne a Scott Date: 6.4.11

APPENDIX I: NHS APPROVAL LETTER

Operational Division

NHS

Miss Madalina Toma
Research Student
Pathfoot Building, Room D21
Stirling School of Education
University of Stirling
STIRLING FK9 4LA

Date: 28 April 2011
Our ref: 11-020 11/AL/0045

Enquiries to:
Direct Dial:
Fax No:
E-mail:

Dear Miss Toma

Project Title: Knowledge & attitudes towards ADHD : a cross-cultural comparative study between Scotland and Romania

Thank you for your application to carry out the above project. Your project documentation (detailed below) has been reviewed for resource and financial implications for NHS Operational Division and I am happy to inform you that NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
Protocol	1	1 January 2011
Summary/synopsis	1	1 January 2011
Letter from statistician		31 January 2011
Letter from sponsor		1 February 2011
Investigator CV		1 February 2011
Evidence of insurance or indemnity		1 February 2011
IRAS SSI Form	3.1	2 March 2011
IRAS R&D Form	3.1	7 March 2011
REC letter requesting further information following initial review		10 March 2011
Response to REC letter of 10.03.11		Undated
REC provisional favourable opinion letter		8 April 2011
Various documents referred to in REC correspondence		
REC letter confirming evidence of compliance with conditions		13 April 2011

The terms of the approval state that you the investigator authorised to undertake this study within NHS with assistance from Dr Chris and Ms Lindsay There is no requirement for site specific assessment review in this case.

The sponsors for this study are University of Stirling.

Details of our participation in studies will be included in annual returns we are expected to complete as part of our agreement with the Chief Scientist Office. Regular reports of the study require to be submitted. Your first report should be submitted to Dr A , R&D Manager, R&D Resource Centre,

( ) in 12 months time and subsequently at yearly intervals until the work is completed. A Lay Summary will also be required upon completion of the project.

In addition, approval is granted subject to the following conditions, where applicable:-

- All research activity must comply with the standards detailed in the Research Governance Framework for Health & Community Care (http://www.cso.scot.nhs.uk/publications/resgov/resgov.htm)

- Health & safety regulations, data protection principles, other appropriate statutory legislation and in accordance with Good Clinical Practice (GCP).

- Any amendments which may subsequently be made to the study should also be notified to Aileen , Research Governance Officer , as well as the appropriate regulatory authorities. Notification should also be given of any new research team members post approval and/or any changes to the status of the project.

- This organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research. You will be required to assist with and provide information in regard to monitoring and study outcomes (including provision of recruitment figures to the R&D office when required).

- As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT Security Policies, until the destruction of this data.

- Permission is only granted for the activities for which a favourable opinion has been given by the REC (and which have been authorised by the MHRA where applicable).

- The research sponsor or the Chief Investigator or local Principal Investigator at a research site may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office) should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

I would like to wish you every success with your study and look forward to receiving a summary of the findings for dissemination once the project is complete.

Yours sincerely

Dr Gordon G
Medical Director, Operational Division
Cc : Research Governance Officer, NHS
Dr Chris

APPENDIX J: INFORMATION SHEET FOR TEACHERS

***Project title**: Knowledge and attitudes towards Attention Deficit Hyperactivity Disorder (ADHD);*

***Principal Investigator**: Madalina Toma, Research Student, Stirling School of Education, University of Stirling;*
***Supervisor**: Professor Julie Allan, Deputy Head of Department, Stirling School of Education, University of Stirling;*

INFORMATION SHEET FOR TEACHERS

Dear Teacher,

My name is Madalina …

I would like to invite you to take part in my research study. This information sheet will help you to understand why the research is being done and what you will be asked to do. It should not take longer than 10 minutes to read.

The information sheet is divided into two sections. **Part 1** contains general information about my study and will give you an overview about what it is involved if you agree to take part**. Part 2** gives you more detailed information about how the study will be conducted.

PART 1

THE BACKGROUND TO THE STUDY

What is the research about and who is doing it?

I am inviting you to take part in a research that I am carrying out as requirement for obtaining a degree of Doctor of Philosophy of Education. The project is funded by the School of Education, University of Stirling and the Economic and Social Research Council.

I have been interested in studying Attention Deficit Hyperactivity Disorder *(*ADHD) for the last 5 years and this PhD research will give me the opportunity to find out more about how teachers feel, think and act in relation to ADHD.

Why is the research being done?

I am really interested to learn more about what you know about ADHD and to understand your attitudes and opinions about it. The importance of teachers' role is often overlooked in research and therefore this project will represent a key opportunity to learn more about your pedagogical experiences, which may help other teachers and professionals to understand better the challenges that children diagnosed with ADHD are faced with.

Why have you been invited to take part in this project?

You have been approached to take part because you are currently teaching in a mainstream primary school. Approximately 100 teachers and support staff will be invited to take part in this research.

What will I be asked to do?

In order understand what the ADHD diagnosis means to you, I will initially ask you to complete a brief questionnaire which will take no more than 10-15 minutes to fill in.

Due to time constraints I will then randomly select just a small number of teachers who will be invited to take part in a 60 minutes tape-recorded face to face interview. During the interview, we will discuss the questionnaire items further. If you decide to take part, we will meet on a maximum of two occasions:

- First meeting: completing the questionnaire-approximately 20 minutes;
- Second meeting (only if selected): taking part in a face to face interview with me-approximately one hour;

Overall, these meetings will be arranged between June 2011 and December 2011. Participants will be personally contacted and questionnaires and interviews will be carried out within the school environment at an agreed time. However, I am very flexible and I will not have any problems travelling to your home or any other place at your convenience.

Do I have to take part?

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting your teacher status or the relationship with other teachers or school staff.

Are there any possible benefits of taking part in my study?

Previous studies have found that people like to be offered the opportunity to discuss their experiences. Your involvement in the study may give you satisfaction that you have contributed to important research, which may affect the future care offered to children diagnoses with ADHD. I cannot guarantee that you will benefit directly from taking part in this study but the information we gather will hopefully help to improve our understanding of how teachers respond to ADHD. Being part of this project will give you the opportunity to express your voice and help other teachers to learn from your personal and direct experience. At the end of the study, I am planning to organize a group meeting where all the participants will be invited, having the chance to meet each other and exchange opinions and advice.

Will there be any risks or is there anything for me to be worried about if I take part?

I do not anticipate any major risk or severe discomfort as a result of taking part in my study. However, I am aware that answering questions and speaking about the ADHD diagnosis might put you in an uncomfortable position. If any aspect of the interview upsets you, we can end the interview at any time.

Thank you very much for reading so far!

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED IN THE STUDY?

How will my confidentiality be protected?

Information obtained for this study will be kept private and confidentiality will be maintained throughout the whole process. The data you provide will be digitized, coded and protected from unauthorized access, use, change, disclosure and destruction. No electronic or hard copy will include any information that would in any way personally reveal your identity. As your input and insight is considered to be highly valuable, the results of this study may be published or used for other academic purposes, teaching materials, training events and workshops. However, the information you provide cannot be traced back to you, unless otherwise agreed.

If you join the study, the personal information which relates to you such as addresses and signed consent forms, will be kept locked away securely at the University of Stirling. My two experienced supervisors (Professor Julie Allan and Dr. Ralph Catts) will have access to the research data, but in a coded way. They will want to check that the study is being carried out correctly. Please do not forget that all the individuals involved in this project will have the duty of confidentiality.

What will happen after I gather all my data?

After collecting my data I will submit a PhD thesis and I will send you a brief overview of the research findings.

Who has reviewed the project and said it is okay?

The research has been approved by the University of Stirling and the Economic and Social Research Ethics Committees. In addition, Stirling Council Education Department has also given its approval.

What happens if there is a problem or something goes wrong?

It is highly unlikely that something will go wrong during this research. However, if you have any concerns about the research you should contact my Principal Supervisor.

Professor Julie Allan
Deputy Head of Department, Stirling School of Education, University of Stirling, FK9 4LA
E-mail: j.e.allan@stir.ac.uk, Tel: 01786467622

How can I obtain more information if I wish?

If you have any questions, I will be glad to answer these.

Madalina Teodora Toma,
Research Student, Stirling School of Education, FK9 4LA
E-mail: m.t.toma@stir.ac.uk, Tel: 07850121831

If you are interested in finding more about your rights in this study, please contact:

University of Stirling
Research Ethics Committee
Tel: +44(0) 1786 467041
The Economic and Social Research Council
Tel: 01793 413000
Email: ethics@esrc.ac.uk

Professor Richard Edwards
Head of Department
The Stirling School of Education
Pathfoot Building, Room A 41
Tel: 01786 466264
E-mail: r.g.edwards@stir.ac.uk

Thank you for taking the time to read this Information Sheet and for considering taking part in this study!

If you have any questions please do not hesitate to ask!

***Project title**: Knowledge and attitudes towards Attention Deficit Hyperactivity Disorder (ADHD); A cross-cultural comparative study;*
***Principal Investigator**: Madalina Toma, Research Student, School of Education, University of Stirling;*
***Supervisor**: Professor Julie Allan, Deputy Head of School, School of Education, University of Stirling;*

APPENDIX K

INFORMATION SHEET FOR PARENTS/CARERS

Dear Parent,

I would like to invite you to take part in my research study. This information sheet will help you to understand why the research is being done and what you will be asked to do. It should not take longer than 15 minutes to read.

The information sheet is divided into two sections. **Part 1** contains general information about my study and will give you an overview about what it is involved if you agree to take part. **Part 2** gives you more detailed information about how the study will be conducted.

PART 1

THE BACKGROUND TO THE STUDY

What is the research about and who is doing it?

I am inviting you and your child diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) to take part in a research that I am carrying out as requirement for obtaining a degree of Doctor of Philosophy of Education. The project is funded by the School of Education, University of Stirling and the Economic and Social Research Council.

I have been interested in studying ADHD for the last 5 years and this PhD research will give me the opportunity to find out more about how parents, teachers and children themselves understand and manage this diagnosis.

Why is the research being done?

A considerable part of this project has evolved from my early interest in ADHD. Working as an educational psychologist for one Romanian primary school, I had extensive contact with students diagnosed with ADHD. During my practice, I became aware that in working effectively with students, many factors have to be considered. Not only teachers, but also parents and children have an important story to tell. I am really interested to learn more about what you know about ADHD and to understand your attitudes and opinions about it. By taking part in this study you will be providing important information about what it means to be a parent of a child diagnosed with ADHD, which may help other parents, teachers and professionals to understand better the challenges that children are faced with.

Why have you been invited to take part in this project?

You have been approached to take part because your child is currently attending the Paediatrics Clinic at Victoria Hospital from Kirkcaldy. I have asked Dr. Steer to approach you to see if you would be interested in helping me with this project. You were selected mainly because your child was diagnosed with this condition and he/she is currently enrolled in a mainstream primary school. Approximately 70 families have been approached but I will only find out who has been contacted after you agree to take part.

What will I be asked to do?

In order understand what the ADHD diagnosis means to you, I will initially ask you to complete a brief questionnaire which will take no more than 20-25 minutes to fill in.

Due to time constraints, I will then randomly select just a small number of parents who will be invited to take part in a 60 minutes tape-recorded face to face interview. During the interview, we will discuss the questionnaire items further. Primary school teachers will also be involved in the research, their knowledge and attitudes being extremely important for the educational and social development of children diagnosed with ADHD. In the last stage, I will conduct a short interview with your child trying to understand his/her meanings, understandings and feelings associated with having the diagnosis of ADHD. I will do my best to accommodate your child's schedule so that he/she does not miss important school classes or other activities. If you decide to take part, we will meet on a maximum of three occasions:

- First meeting: completing the questionnaire-approximately 20 minutes;
- Second meeting (only if selected): taking part in a face to face interview with me-approximately one hour;
- Third meeting (only if selected): facilitating the discussion with your child-approximately one hour;

Overall, these meetings will be arranged between May 2011 and December 2011 at a mutually agreed time and place. I am very flexible and I will not have any problems travelling to your home or any other place at your convenience.

Do I have to take part?

Participation in this study is entirely voluntary and you are free to refuse to take part or to withdraw from the study at any time without having to give a reason and without this affecting your future medical care, your relationship with the medical staff looking after your child or the teachers at school.

Are there any possible benefits of taking part in my study?

Previous studies have found that people like to be offered the opportunity to discuss their experiences. Your involvement in the study may give you satisfaction that you have contributed to important research, which may affect the future care offered to children diagnoses with ADHD. I cannot guarantee that you will benefit directly from taking part in this study but the information we gather will hopefully help to improve understanding of what parents think, feel and experience in relation to their child diagnosed with ADHD. Being an active part of this project can give you the opportunity to get your voice heard and to help other parents to learn from your own experience. Furthermore, this is the first research project conducted in Scotland that is particularly interested in how ADHD in understood by parents, teachers and children themselves. At the end of the study, I am planning to organize a group meeting where all the participants will be invited, having the chance to meet each other and exchange opinions and advice.

Will there be any risks or is there anything for me to be worried about if I take part?

I do not anticipate any major risk or severe discomfort as a result of taking part in my study. However, I am aware that answering questions and speaking about the diagnosis of your child might put you in an uncomfortable position. If any aspect of the interview upsets you we can end the interview at any time. Moreover, if you are worried about how your child will react during the interview, you can remain nearby and keep an eye on what is happening.

Thank you very much for reading so far!

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

WHAT WILL HAPPEN TO THE INFORMATION COLLECTED IN THE STUDY?

How will my confidentiality be protected?

Information obtained for this study will be kept private and confidentiality will be maintained throughout the whole process. The data you provide will be digitized, coded and protected from unauthorized access, use, change, disclosure and destruction. No electronic or hard copy will include any information that would in any way personally reveal your identity. As your input and insight is considered to be highly valuable, the results of this study may be published or used for other academic purposes, teaching materials, training events and workshops. However, the information you provide cannot be traced back to you, unless otherwise agreed.

If you join the study, the personal information which relates to you such as addresses and signed consent forms, will be kept locked away securely at the University of Stirling. My two experienced supervisors (Professor Julie Allan and Dr. Ralph Catts) will have access to the research data, but in a coded way. They will want to check that the study is being carried out correctly.

If you decide to participate in the study, I am asking for permission to inform your GP that you and your child will take part in this research. Please do not forget that all the individuals involved in this project will have the duty of confidentiality, although I am legally obliged to report any issues concerning child protection.

What will happen after I gather my data?

After collecting my data I will submit a PhD thesis and I will send you a brief overview of the research findings. Unfortunately, due to time constraints, there will be no individual feedback available.

Who has reviewed the project and said it is okay?

The research has been approved by the University of Stirling and the Economic and Social Research Ethics Committees. In addition, Fife & Forth Valley Research Ethics Committee has also given its approval. It is a requirement that your records in this research, together with any relevant medical records, be made available for scrutiny by monitors from NHS Fife & Forth Valley and the Regulatory Authorities, whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

What happens if there is a problem or something goes wrong?

It is highly unlikely that something will go wrong during this research. If you have any concerns about the research you should contact my Principal Supervisor.

Professor Julie Allan, Deputy Head of School, Stirling School of Education, University of Stirling, FK9 4LA, E-mail: j.e.allan@stir.ac.uk, Tel: 01786467622;

How can I obtain more information if I wish?

If you have any questions, I will be glad to answer these.

Madalina Toma, Research Student, Stirling School of Education, University of Stirling, FK9 4LA, E-mail: m.t.toma@stir.ac.uk, Tel: 07850121831;

You can discuss the study with friends and relatives, your GP or other professionals before deciding whether to take part. Even if you agree to take part now, you can still change your mind or refuse to participate at a later stage.

If you are interested in finding more about your rights in this study, please contact:

University of Stirling
Research Ethics Committee
Tel: +44(0) 1786 467041
The Economic and Social Research Council
Tel: 01793 413000
Email: ethics@esrc.ac.uk

Professor Richard Edwards
Head of School
Stirling School of Education
Pathfoot Building, Room A 41
Tel: 01786 466264
E-mail: r.g.edwards@stir.ac.uk

Thank you for taking the time to read this Information Sheet and for considering taking part in this study!

If you have any questions please do not hesitate to ask!

APPENDIX L:

GP LETTER

KNOWLEDGE AND ATTITUDES TOWARDS
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD);
A CROSS-CULTURAL COMPARATIVE STUDY BETWEEN SCOTLAND AND ROMANIA

Patient Details
Name:
Date of Birth:

Dear Doctor,

My name is Madalina Toma and I am currently in the second year of my PhD founded by the Stirling School of Education, University of Stirling and the Economic and Social Research Council (ESRC). My research is focusing on the general knowledge and attitude towards Attention Deficit Hyperactivity Disorder, (ADHD), being a cross-cultural comparative study between Scotland and Romania. More specifically, I am interested to explore what kind of knowledge and attitudes about ADHD do parents adopt and how do children experience ADHD in the context of their everyday life.

I am contacting you to inform you that the above patient is taking part in my study. During my field work, I will ask his mother to complete a short questionnaire and subsequently to take part in a more detailed interview. In the

last part of the project, I will also involve the child, having a discussion about his experiences of living with ADHD. A copy of the patient information sheet is enclosed

However, I want to assure you that this research does **NOT** involve any changes in standard treatment and the patient will be treated in an ethical and professional manner. Taking into consideration that the complexity of ADHD requires a multi-modal, multi-professional and multi-agency approach, I am counting on all your help and support during this process.

I would be happy to provide you with a copy of my final thesis, any suggestions and recommendation being highly appreciated. If you have any questions, concerns or complaints about the research, please do not hesitate to contact me. I will be glad to answer any of your questions.

My contact details are:

Madalina Teodora Toma
Research Student
The Stirling School of Education
Pathfoot Building
Room D 21
E-mail: m.t.toma@stir.ac.uk
Tel : 07850 121 831

Professor Richard Eduards
Head of Department
The Stirling School of Education
Pathfoot Building
Room A 41
E-mail: r.g.edwards@stir.ac.uk
Tel: 01786 466264

Thank you very much for your co-operation!

Yours sincerely,
Madalina Toma